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EDINBURGH

**FACTORS AFFECTING WORK PERFORMANCE OF  
HEALTH PRACTITIONERS IN JAZAN,  
KINGDOM OF SAUDI ARABIA**

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## **FACTORS AFFECTING WORK PERFORMANCE OF HEALTH PRACTITIONERS IN JAZAN, KINGDOM OF SAUDI ARABIA**

### **Abstract**

**Aim.** This study aimed to explore factors influencing health practitioners' work performance. This knowledge will facilitate development of appropriate support and education for health practitioners in delivering quality healthcare.

**Design and participants.** A mixed method exploratory descriptive study using cross-sectional methodology was used to gather relevant data and obtain an overview from 60 health workers and 40 health managers in health facilities operated by the Ministry of Health (MOH) in Jazan region, Saudi Arabia. Survey questionnaire followed by selected unstructured interviews to gather data were used. Descriptive statistics, particularly the percentage and weighted mean (Wm) were used.

**Findings:** Results showed that a typical health practitioner in Jazan, KSA has a mean age of 31.17 (health workers) and 28 (health managers). Majority are female (68.33% health workers; 85% health managers) and from other Asian countries. Most have Diploma in Nursing/Midwifery (46.67% health workers; 55% health managers) as educational qualification. Many of them are charge nurses (41.67%). The average number of years they have worked is 6.92 years for the health worker and 12.63 years for the health managers. The health workers showed agreement on the utilization of performance appraisal in their unit (Wm=3.66); however, they were uncertain on their appraisal regarding remuneration, benefits, and recognition (Wm=3.30) as well as uncertain on staffing and work schedules (Wm=3.01) and staff development (Wm=2.39). Factors affecting their work performance were generally intermediate in nature (Wm=2.39), but shortage of staff specifically was a major factor (Wm=3.27). They perceived the strategies to improve and maintain excellent performance as moderately needed (Wm=2.23). Health managers were often involved in management tasks (Wm=2.89) and they assessed their skills as "Good" (Wm=3.63).

**Conclusion.** Many of the health practitioners in Jazan are predominantly younger, female expatriates. They encounter issues in their job and in management that may affect their work performance. Addressing these issues is necessary to assist their development and support work performance. The strategic plan developed from these results will support the education and training of these health practitioners and will be implemented and evaluated.

**Keywords:** Expatriates, Health Managers, Health Workers, Management Skills, Work Performance

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## **CHAPTER 1: INTRODUCTION AND CONTEXT**

### **1.0 Introduction**

In the advent of new generation of health practitioners, one can perceive that these young generations are more theoretically and clinically competent, strategic and well-modulated with regard to work performance. Yamada (2002), in research conducted in the United States, suggested that home care aides today are generally younger, more educated, and more likely to hold full-time positions compared to their counterparts 10 years ago. Aligning with Yamada, my personal experience working as a health provider for 18 years and observing first-hand the work performance of healthcare workers in Saudi Arabia from the 90s to the present supports that this would also seem to be the case in Saudi Arabia.

On my starting years in the early 90s as a staff nurse in King Fahd Central Hospital, the only hospital in Jazan region accredited by Central Board of Accreditation for Healthcare Institutes (CBAHI), I experienced working with a multinational workforce and observed the commitment and type of work demonstrated by each staff with little observed support from the management and superiors. In the span of approximately two decades, the directorate of health affairs in Jazan were able to provide manpower in health care facilities locally and from foreign recruits (Pallot, 2011), mostly coming from Asian countries. However, due to the increased population in the region, the project of the Ministry of Health to expand and open new hospitals and health clinics, eventually brought back instability related to manpower.

Although staffing and proper management of staff is always a main issue in terms of health care workers (Almalki, Fitzgerald, and Clark, 2011), maximizing the recruitment from foreign countries has been the only solution to fill in the gap of healthcare manpower in the region. Despite the efforts made over the past decade, the problem has remained unchanged, becoming the status quo. The Ministry of Labour has also been trying to implement a Saudization policy in the Ministry of Health (MOH), especially in the medical and nursing specialties, which took effect in 11 June, 2011 (Department of Labor and Employment Philippines, 2017). As of the MOH data, from 2007 - 2013 in the Directorate of Health in Jazan Region, there are approximately 20 hospitals and 155 Primary Health Care Centres (Saudi Ministry of Health, 2017) catering to the needs of a population of approximately 1.5 million, from the 2010 census (Jazan University, n. d.). During the same time

frame of 2007- 2013, a census for physicians found an increase of 61% from 1,468 physicians to 2,383, while nursing staff census from 2007 was 4,595 with a significant increase of 59% in 2013 to 7,771, according to the MOH portal (Saudi Ministry of Health, 2017). The remaining problems between the population and health workers in the region are evidenced in these data and are supported by the insufficiency in the nurse-to-patient ratio in the kingdom, which is 1:203 compared to a ratio of 1:102 in the United States (Arab News, 1st October 2013).

In my work as a nurse supervisor under the Regional Nursing Administration (RNA) in 2003, I encountered various complaints, both written and verbal, from healthcare workers, mostly nurses. These complaints first were received verbally from different hospitals during my regular rounds. In turn, complaints were properly documented for the purpose of collaboration, taking appropriate measures, and updating the policies with the respective managers of the hospitals. Most of the complaints related to heavy workload, poor staffing, and performing non- nursing tasks. However other factors such as burnout; lack of opportunity for professional development; dissatisfaction with the management practices, incentives, and lack of acknowledgement of good performance; and poor staff relationships also were identified. As the director of the regional training in Jazan, I initiated collaboration with the directorate of health affairs in the region to open courses and training that would enhance the clinical skills of nurses, as well as symposiums that could update their knowledge in medical sciences. This was based on the work in doctoral modules APP A and B. However, this initiative is only the beginning of the solution; this research will explore other factors that may need to be considered.

From the different views and findings obtained from the literature, there is urgency in looking into factors affecting work performance of healthcare practitioners. Although some results and semblances could be similar in nature to prior research, differences are expected in the sense that culture is the primary aspect, as the setting of the present study is the most conservative Muslim country in the world. In addition, it has been noted and documented that healthcare facilities in the kingdom are dominated by expatriates. Thus, the current study is a novel venture in trying to improve work performance of health practitioners in the Saudi Arabia.

Given the current healthcare situation in Jazan, Saudi Arabia, this proposed study will collect information about the status, conditions, and experiences of nurses of different races currently

employed in healthcare facilities operating under the Ministry of Health in this region of the Kingdom of Saudi Arabia, serving an approximate population of 1.5 million (Jazan university, n.d.). The information to be gathered may shed light on the nurses' assessments of their workplace, incentives and any other issues affecting their work performance as health practitioners. Knowing and analysing the issues may contribute to the development and promotion of employee morale once these issues are addressed, and consequently, also raise the satisfaction level of patients in these healthcare facilities.

Health practitioners as defined in Article 1 of the Guideline of Professional Classification and Registration for Health Practitioners (2014) in Saudi Arabia are those who have genuine qualifications and experience for the safe practice in the healthcare sector. In this study, they are employees in healthcare facilities providing services according to their educational qualification, training and job description in relation to provision of healthcare to the public. They are composed of two groups, which are health workers and health managers. The health workers are those assigned in the nursing and medical category. The nursing category includes the charge nurse, head nurse, and nurse supervisor; in the medical category are the residents, specialists, and consultants. The health managers are composed of nurse manager, nursing deputy director, and unit manager.

## **1.1 Context**

In this section, the macro and micro situation relating to health care provision and staffing is explored. This commences with the international perspective followed by the national perspective and finally reviewing the local perspective. A short conclusion of the main research issues is given.

### **1.1.1 International perspectives**

According to the World Health Organization (WHO), health planning is critical in the development of the healthcare sector in the western pacific region, mobilizing the health planning development to different countries such as China, Japan, Papua New Guinea and other countries in the world (World Health Organization Western Pacific Region, 2017). Health planning is an investment for socio-economic development (LAO People's Democratic Republic Ministry of Health, 2011).). Therefore, the present work includes a profile of healthcare workers in selected international

countries. This is a way of looking into the prevailing circumstances in those countries so that it could be compared with existing situations in Saudi Arabia.

In Japan, Yamada (2002) looked into the profile of home care aides, nursing home aides and hospital aides. He examined population data from 1997 to 1999 and compared the data from the population survey from 1987 to 1989. His study revealed that demographic characteristics and work conditions of hospital and nursing home aides, showing little change over the decade with the exception of home care aides, who were found to be younger in age, more educated, more likely to hold full-time positions, and more likely to have health benefits compared to their counterparts 10 years ago. Yamada also reported that the shortage of professional health care workers was a serious problem. Yamada's findings implied an improved qualification brought about by health regulations, which consequently were implemented in schools as curricular program innovations. The situation is similar in the case of Saudi Arabia. The kingdom opened new universities of higher education that encouraged the opening of allied health science courses. Further, the admission of women in higher education taking allied health courses has become popular as well.

In the United States, the New York Centre for Health Workforce Studies documented the profile of their health workforce (University at Albany, State University of New York, 2017). In particular, the report mentioned that California had more than 200,000 actively practicing Registered Nurses, the most of any state, but was found to have the fewest RNs per capita in the nation. The New England census division had the most RNs per capita, with 72% more than the Pacific division, which was found the fewest. The East South Central census division had the most Licensed Practical Nurses (LPNs) per capita, more than twice than the Pacific census division, which was found to have the fewest. More than 21% of LPNs were Black/African-Americans. In addition, Hispanics/Latinos were substantially underrepresented in nursing, comprising 6.1% of RNs and 3.2% of LPNs, even though these groups represented nearly 13% of the general population. The number of RN and LPN degrees awarded increased by 18% and 22%, respectively, while number of post-RN degrees declined by 6%. This data implies an unequal distribution of nurses in the United States, although expatriates (not as common in the U.S.) were not included. However, the data highlight the shortage of nurses, specifically in the U.S., which could be the

result of a strict implementation of an ideal nurse-patient ratio to attain effective nursing performance.

Aside from effect of policies as cited above, the low percentage of RNs in the United States could stem from the perceived facilitators and barriers to baccalaureate completion among Registered Nurses with an associate's degree (Schwarz and Leibold, 2014). Although Schwarz and Leibold (2014) noted a strong movement in the United States to increase the percentage of baccalaureate-prepared RNs, the percentage of associate-prepared RNs who go on to pursue baccalaureate education remains low. The authors used a convenience sample of 82 associate-prepared RNs to obtain data on perceived facilitators and barriers to progression toward baccalaureate nursing education. After analysis of the data collected, Schwarz and Leibold found that facilitators included a desire for professional growth, professional and career enhancement, and friendliness and encouragement by others. Barriers centered on family and job constraints, financial concerns, and lack of differential treatment between associate-prepared RNs and baccalaureate-prepared RNs.

Educational advancement in the profession is also important to keep the person abreast of recent trends and practices in the field. Much more, hospitals operate within special areas, which mean the recruitment of nurses who have specializations. If recruitment is difficult, training their present staff is an alternative. Another alternative is to increase the number of men in nursing careers, which has remained proportionally low. Relative to this, the Hodes Research group ([www.aamn.org](http://www.aamn.org)) designed an on-line survey about men in nursing. It was developed in conjunction with the California Institute for Nursing and Health Care, Coalition for Nursing Careers in California and in consultation with the assembly for Men in Nursing. The survey was administered from October 17 to December 15, 2004, collecting a total of 498 completed surveys. Of this number, 93% were Registered Nurses while 7% were nursing students. The findings showed that the top nursing specialties among these male respondents included critical care (27%), emergency department (ED; 23%), and medical/surgical (20%). It was also noted that top areas of expertise included middle management (19%), educator (15%), director and nurse practitioner (10% each). There were also other categories noted as home health, long-term care, and nurse informatics. As to their biographical profile, these male nurses had an average age of 44 years of

age, with the largest age segment between 45 and 54 years (38%). Half of the respondents were under 45 years old, while about one third were between 35 – 44 years old; nearly 17% were between 25 – 34 and 10% between 55 -64 years old. As to their length of years in the nursing service, they had been in the profession for about 14 years on average. The largest proportion surveyed had between 5 and 10 years of experience (23%) followed by 10 -15 years of experience (17%), and those with 20 – 25 years of experience was 16%. The majority of the respondents or 54% had over 10 years of professional experience. These findings show that the male nurse respondents were working in different specialties and fields, were predominantly in their middle ages, and had been in the practice for quite a long time already. This implies that they have gained much experience already, which contributes to their success and good work performance.

Another source providing a profile of health workers was based on the report by Lehmann and Sanders (2007) to WHO. This report was limited to commenting on gender, age and marital status of community health workers. As to gender, in their review of articles for the report they noted that most did not identify the gender of community health workers. However, 17 articles specified gender and they noted a predominance of female health workers, with 70% female, 12% males, and about 18% could be a combination of both male and female. The report further pointed out that articles on community health workers in Bangladesh and Pakistan mentioned the gender of their health workers while articles on programmes in Latin America in most cases did not. Hence, they assumed that gender issue is to a very large extent influenced by wider societal practices and beliefs and gender relations. The authors cited the situation in Somalia where most health workers were male. As such, a gender problem emerged in that male health workers had little contact with women. To some extent, similar cases are experienced in Saudi Arabia. Male health workers go with ambulance to pick up patients and victims accidents. As to age of the health workers, again they found out that it was less frequently mentioned, although they cited the work of Ofosu-Amaah in 1983 that community health workers were mature in age (between 20-45 years and often had a married status).

To have general information about the profile of health workers, the World Health Organization (WHO, 2006) published in 2006 based on the WHO regions. The report presented the total health workforce based on a density per 1000 population, viz: Africa = 2.3; Eastern Mediterranean = 4.0;

South-East Asia = 4.3; Western Pacific = 5.8; Europe = 18.9 and Americas = 24.8. Apparently, the Americas have the highest ratio of health workforce per 1000 population followed by Europe compared to other WHO regions. These data provide two implications:(a) the Americas and Europe have more developed countries which report a lower population growth rate; and (b) many health workers go to countries in those regions because of the belief that they get better salaries and benefits as well as a better socio-economic environment. Although Saudi Arabia claims that health facilities are dominated by expatriates, the ratio for the region where it belongs (South-East Asia) is low. The low ratio is affected by higher population growth in these countries. With this scenario, there is really a shortage of health workers in the South- East Asia region, which includes Saudi Arabia.

In another study about work performance of nurses in the United States, De Lucia, Ott, and Palmieri (2009) conducted a narrative literature review of nursing research spanning 2002 – 2005. After they had reviewed literature of nursing performance, which included cognitive, physical, and organizational factors that affect such performance, they concluded that nurses' work system often do not accommodate human limits and capabilities and that nurses work under cognitive, perceptual, and physical overloads. With these, they recommended that human factors and ergonomics must play a key role in the redesign of the nurses' work system. This would determine how overloads can be reduced and how the limits and capabilities of performance can be accommodated.

From the different literature reviewed, it appears that nurses in many hospitals come from diverse cultural backgrounds. The study by Dimabayao (2002) was focused on the assessment of transcultural nursing staff in primary health care centres in Burayda, Al-Qassim, Kingdom of Saudi Arabia. A sample of 200 transcultural nursing staff were used as respondents in the study. As to the profile of these respondents, Dimabayao found that the typical transcultural nursing staff was an Asian who came mostly from the Philippines, married, female, Catholic by religion, with a college degree in nursing and who receives a monthly salary of \$600. On average, these nurses have been working for an average of 10 years, are generally employed in a dispensary in urban areas, and mostly work as a reliever in the female room. This condition implies that these transcultural nurses cannot become a regular staff until they are familiar with Saudi culture in



health and language, which is because communication is vital to carrying out the work of a nurse. Furthermore, many of these transcultural nurses were under the care of an agency and it was only in later years that Saudi Arabia hired healthcare providers directly from other countries to solve the problem of nursing shortages. A more detailed section on the nursing backgrounds in Saudi Arabia is given in Appendix A.

### **1.1.2 Healthcare in the Kingdom of Saudi Arabia**

The healthcare system is the most important service in any country (Al-Mulhim, 2013) as the development and growth of the nation is dependent on the capabilities of the nation's population. This is substantiated in the Saudization policy, which is the government's response to improve employment participation of Saudi nationals in the private sector and ultimately address the Kingdom's unemployment problem (Department of Labor and Employment Philippines, 2017). In the Kingdom of Saudi Arabia (KSA), the Ministry of Health (MOH) is the primary agency responsible for the provision of preventive, curative, and rehabilitative healthcare for the population. The structure of the healthcare system in the KSA has two tiers: the first tier is a network of primary healthcare centres and clinics as well as mobile clinics for remote rural areas; the second tier is composed of hospitals and specialized treatment facilities usually found in urban areas. As far as hospital management is concerned, the MOH operates 62% of the hospitals and 53% of the clinics and centres. The rest are under government agencies like the Ministry of Defence and Aviation, the National Guard, the Ministry of Interior and other ministries who cater to the health needs of their staff and families. There are also teaching hospitals attached to the medical faculties of universities in the kingdom (Metz 1992). This diversity of health care provision and management may affect the country's ability to offer standardised level and quality of care. The hand in hand collaboration of different government agencies is very much dedicated in improving quality care so as to improve the quality of life of an individual inside the Kingdom.

The estimated population of Saudi Arabia, based on July 2013 statistics, was 9,939,583. This includes the 5,576,076 foreigners who came here as expatriates. During that year, the population growth rate was 1.51% as a result of high birth rate (Indexmundi, 2017). The data show that there are more expatriates compared to the locals owing to the fact that employers extend the privilege of bringing expatriate families to Saudi Arabia. These demographics imply the need for more healthcare workers to provide health services to the growing population.

With the growing population in the Kingdom of Saudi Arabia, the MOH has developed the Integrated and Comprehensive Healthcare Plan (Albugami, 2013) and updated their facts and achievements for the whole kingdom of Saudi Arabia including Jazan region (where this research is undertaken) from 2010 – 2020 (Appendix B). This report has revealed that implementation of a number of large healthcare projects in the Jazan region has reached about 70% and is still ongoing. Health care projects currently undergoing construction, tender or contracted in the kingdom, include general hospitals, central hospitals, health centres and initial healthcare centres, psychiatric hospitals, diabetes centres and malaria control centres. The projected construction of health facilities until 2020 is a total of 26 hospitals and specialized centres where 12 centres still under construction (MOH, 2017). Hence there is a need of highly qualified and trained healthcare practitioners to become staff in these healthcare facilities in the region. Infrastructures being designed to offer a good ambiance in giving a healthcare plan need further help from healthcare individuals to deliver realistic improvements in patient care. It is necessary to build up both technical side and labour side when we are prospecting a future benefits and thus this research will assist in establishing what needs to be done for staff development.

### **1.1.3 Healthcare in Jazan Region**

Geographically, Jazan region stretches some 300 kilometres along the Red Sea coast, just north of Yemen. It covers an area of 11,671 square kilometres with Jizan City as its capital. It is the second smallest region in Saudi Arabia. However, the study by Salam (2013) shows its population increased markedly. Comparison of census data from 1974 -2010 shows Jazan now ranks 6<sup>th</sup> (1,332,26 population) compared to other regions, ranks 6<sup>th</sup> in terms of its Saudi population (1,121,527) and ranks 7<sup>th</sup> in terms of its non-Saudi population (210,735). She concluded the following: Firstly, there was growth in population – both native and expatriate, proportionately. Secondly, there were certain regions – Riyadh, Makkah Al-Mokarramah, Eastern Region and Jazan that experienced a fast increase of population as well as households. Thirdly, region wise population growth indicated an urbanization and related infrastructure development. Finally, fast increasing native population in regions like Riyadh, Makkah Al-Mokarramah, Eastern Region and Jazan shows rural to urban migration.

Salem (2013) indicated that Saudi Arabia's population size and growth has implications on policy making to strengthen public utility service provisions. Among such public utility service is

healthcare facilities and services. Thus, in 2012, the MOH of the kingdom allocated SR 2 billion for its development work in Jazan to provide healthcare facilities and hospitals with a total of 3,495 beds within the governorate (Rasooldeen, 2012).

With the above magnitude of infrastructure projects on healthcare in Jazan, the deputy minister of health for therapeutic medicine of the kingdom pronounced that around 600 people will be provided with employment opportunities in these hospitals. Recruitment of healthcare workers who possess the necessary qualifications, and the development of those ones already in the service are crucial tasks, which hospital managers and their human resources office will undertake. Thus, preparing a strategic plan at this point to address issues relating to health practitioners and to their ability to stay abreast of current trends and practices in healthcare is seen as a novel venture to provide quality healthcare and satisfaction of patients and will be addressed in this research.

#### **1.1.4 Healthcare professionals in Saudi Arabia**

To understand the current staff situation of health care professionals, it is necessary to review the development of this role in Saudi Arabia. Almalki, Fitzgerald, and Clark (2011) reviewed the historical development and current structure of the health care system in Saudi Arabia. Emphasis was on the public health sector and the opportunities and challenges confronting the Saudi healthcare system. The review revealed a shortage of indigenous Saudi health professionals, absence of a national management crisis policy, and underutilization of the potential of electronic health strategies. Currently, the shortage of Saudi healthcare professionals is overcome by the recruitment of expatriates who make up more than 85% of the country's healthcare staffing system (Simpson 2002) and dominate the number of staff in hospitals and healthcare facilities, making it important to address the needs of this population of the staff (Pallot, 2011; Al-Mulhim 2013). It was noticed that there are few studies (Ahmadi 2008; Al Malki et al., 2012; Alneami et al., 2015) in KSA that explore assessment of health practitioners, particularly in relation to work place, incentives, and factors affecting work performance; therefore, this will be explored in this research.

Recently, the kingdom has expanded its policy for the education of women. This is in accordance with the Saudization policy, but also is one way of addressing unemployment among Saudi nationals (Department of Labor and Employment Philippines, 2017). One way to address this was

to continuously develop nursing schools in the kingdom (nursing training started in 1958 but accepted males only). In 1961, two schools were opened to accept females in 1976, the Bachelor of Science in Nursing degree was offered; and in 1987, the Master of Science in Nursing program was added. However, female enrolment was rather slow due to Saudi culture, which supported parent and student objections based on concerns that this was to prepare women to work with men and to be away from home with long working hours (King Faisal Hospital and Research Center, 2017). The culture of gender segregation in Saudi Arabia, in particular that a female Muslim cannot work among males, affects staffing in Saudi hospitals.

Alongside with this, Balkhair (2012; p. 22) presented the MOH mission when he presented the National eHealth Program of Saudi Arabia. The mission is: " Providing healthcare at all levels, and promote public health, disease prevention and development of laws and regulations governing health sector and public sectors and monitor performance with more focus on research, academic training and areas of health investment."

The public health sector in Saudi Arabia is overwhelmingly financed, operated, controlled, supervised, and managed by the MOH (Country Cooperation Strategy for WHO and Saudi Arabia 2006-2011). It suggests that the MOH vision of ehealth can be well supported by the National ehealth Strategy; this endeavours to seek the active involvement of the large number of employees, from Executive to front line care providers, including the majority of physicians and nurses and other allied health specialties (Ministry of Health, 2017). However, Almalki et al (2011) stated that this model of management may not be able to meet the population's healthcare needs into the future unless serious and well planned measures, which include education and staff development, are implemented to separate these multiple roles. They suggested that one possible measure is to give more authority to regional directorates, such as Jazan. Therefore, this research will form the basis for development of staff in the Jazan region.

Many of the health practitioners in Jazan region are expatriates: 369 Saudi physicians and 2,014 expatriates, while in the nursing fields 4,506 expatriates and 3,265 locals (Ministry of Health, 2017). Almutairi and MacCarthy (2012) cited that a lack of knowledge of Saudi culture among expatriate nurses can lead to cultural conflicts and misunderstanding of some of the behaviours and practices of the indigenous Saudi people. Such cultural misunderstanding may contribute to

problems experienced in the workplace, incentives and problems affecting work performance, aside from socio-cultural dimensions. Alongside this issue are differences in organizational structure and policies in healthcare facilities that are brought about by the form of government where the study is to be conducted. Thus, one can question whether the organizational structure and present policies and practices implemented in healthcare facilities under the Ministry of Health in the kingdom are supportive of healthcare practitioners in the Jazan region. This will be explored through the proposed research.

### **1.1.5 Performance management**

The nursing profession is challenged to ensure the provision of dignity, respect, compassion, and patient-centred care (McSherry, Pearce, Grimwood, and McSherry, 2012). In order to instil public confidence in nursing as a profession and field, leadership, management, and educators must collaborate to contribute to improving the quality of care provided by nurses and the image of nursing more generally (McSherry et al., 2012).

A key tenet in examining the work performance and conditions among nursing staff is the concept of performance management. This concept also encompasses the management of knowledge, particularly in terms of knowledge sharing, across organizational and professional boundaries and the impact on patient safety and quality of care (Currie, Waring, and Finn, 2008). Evidence has supported the impact of performance management on organizational and individual performance and ultimately quality of patient care (West, 2001). Research on performance within the business realm has suggested the importance of decentralized decision-making, staff participation and involvement, innovative work practices, and alignment of structure, strategy, and environment (West, 2001). In fact, Smith (2002) described the British National Health Service use of business models of performance management, which offered the prospect for major improvements in quality of care; however, Smith also noted the requirements of information, leadership, and managerial resources to support adequacy of performance management.

More recent investigations of performance management in different countries have supported the role of clinical governance and knowledge sharing in performance management in healthcare (Tuan, 2013). Excellence in nursing has been shown to be dependent on leadership support for

complex reform through management, education, empowerment, encouragement, and resource management of staff toward innovation in practice (McSherry et al., 2012). Healthcare organizations that demonstrate nursing excellence require shared working partnerships in which nurse managers, leadership, and educators collaborate with their organization (McSherry et al., 2012). Also highlighting responsible leadership, Tuan (2013) found ethical corporate social responsibility (CSR) to support clinical governance in healthcare service organizations, through knowledge sharing practices. Through driving CSR, clinical governance influences the quality of patient care service. In an examination of 417 responses from self-administered questionnaires from clinical staff members in Vietnamese hospitals, Tuan (2014) found CSR to be a strong predictor of effective clinical governance, yielding high quality patient care and affecting brand equity of the hospital. Tuan (2014) concluded that high levels of CSR supports the clinical governance mechanism, which support implementation of initiatives for improved patient care and service quality. Excellence in nursing stems from authentic and sustainable leadership that supports innovation and reform, allowing nurses to provide safe, compassionate, quality care (McSherry et al., 2012).

#### **1.1.6 Challenges and Goals**

The goals of the Integrated and Comprehensive Healthcare (IHC) in the Kingdom of Saudi Arabia remain focused on quality, safety, and satisfaction, which are attained through existing services of the facilities and the human resources. The challenges faced by the MOH in the implementation of the goals of the IHC therefore include (a) performance measures; (b) manpower training and development; and (c) resistance to change. In light of these challenges, this study was designed to evaluate and develop a profile of health practitioners in the Jazan region and the implications to the delivery of services, as well as to support greater understanding of the factors that influence health practitioners' performance and needs. This knowledge would facilitate development of appropriate support and education for health care professions in delivering quality health care. As such, the following research questions (RQ) will guide the study:

RQ1: What is a typical profile of health practitioners in Saudi Arabia and how does this profile affect the delivery of healthcare services in Saudi Arabia?

RQ2: What factors influence health practitioner performance and needs?

## **1.2 Summary**

This first chapter has provided an introduction to and rationale for the study. Chapter 2 provides an exploration of the relevant existing literature on the topic, ending in a summary of main themes to be explored in the research. Following from this, Chapter 3 highlights the theoretical basis of the study, which is used to more deeply understand the study results. Chapter 4 offers insight into the particular methodology and research design for the study, including the data collection and analysis plan used for the study. In Chapter 5, the data analysis findings are presented with basic conclusions. In Chapter 5, these results are discussed in relation to the research questions of the study as well as to the previous literature on the topic. Finally, Chapter 6 provides final conclusions and recommendations based on the study results.

To understand the current circumstances of health care professionals in Saudi Arabia, it is necessary to review the development of this role within Saudi Arabia. This study will do this by looking specifically at health care practitioners in the Jazan region of Saudi Arabia. In order to address specific challenges to the MOH, specifically in terms of the need for training, performance management, and support for innovation and reform (change management), the aim of the study, guided by the research questions, not only was to create and understand a health practitioner profile in the Jazan region, but also to support greater understanding of performance and needs of health practitioners and the factors that influence their performance. The implication of gaining this understanding is the development of nursing support and education aimed at providing high quality health care through excellence in nursing.

## **CHAPTER 2:            REVIEW OF RELATED LITERATURE**

### **2.0      Introduction**

This chapter presents a narrative review of literature identified through the search strategy and established as being relevant to the present work. No specific critical appraisal tools were used in the review of the literature; however, they were reviewed using the framework of the relevant questions identified in the appropriate research Critical Appraisal Skills Programme (CASP) (accessed 17 October 2011 <http://www.casp-uk.net>) for research methodology. Articles were sorted and stored in files based on the themes in the article. For example, all article that related to work performance were filed under this title, however if they also referred to management they would be cross referenced to the file on management articles. A brief overview of the search strategy is given followed by literature relating to factors affecting the work performance of nurses, quality, management and leadership and finally startegies to improve work performance. A section on the theoretical background of the study is then addressed with a short summary to conclude the main issues.

### **2.1      Search Strategy**

The researcher searched relevant literature based primarily on peer-reviewed research, but inclusive of seminal and information based articles, books, and web-based information. Search engines were utilised and included using google scholar, as well as university based online and traditional library resources and online databases including Cumulative Index of Nursing and Allied Health Literature, (CINAHL), Psychology Literature (Psychlit), Applied Social Science Index and Abstracts (ASSIA) and Emerald. Grey literature, including that from Ministry of Health KSA, King Faisal Special Hospital Research Centre, and World Health Organisation publications were also scritinised. Limiters to the search were set on English language and Arabic language publications, peer reviewed journals and texts published in the last 10 years (2005-2015). From the experience and KSA government documentation the following keywords used to search the literature: work performance, health practitioners, nurse, management, quality performance, leadership. These search strategies returned around 5,300 articles and from these 110 were selected following scrutiny of the title, then abstract and finally full text for relevance to the study.



## **2.2 Work performance of nurses.**

As suggested by Kabene, et al (2006) in a narrative article about the importance of human resources management in healthcare, productivity and good performance of a healthcare practitioner ensure that health interventions are delivered efficiently and competently. After exploring published literature and collected data through secondary sources, they concluded that proper management of human resources is critical to providing high quality health care. Another study about work performance of nurses was undertaken by De Lucia, Ott and Palmieri (2009). The study was conducted in the United States using narrative literature review of nursing research selected using a systematic approach and spanning years 2002 – 2005. Having reviewed literature of nursing performance including cognitive, physical and organizational factors that affect such performance, the authors concluded that nurses' work systems often do not accommodate human limits and capabilities and that nurses work under cognitive, perceptual, and physical overloads. With these, De Lucia et al. recommended that human factors and ergonomics must play a key role in the redesign of the nurses' work system. This would determine how overloads can be reduced and how the limits and capabilities of performance can be accommodated.

A further quantitative study by Al-Hamadi (2009) identified the factors influencing performance of hospital nurses in the Riyadh region, Saudi Arabia. With the participation of 923 out of 1,834 nurses in 15 hospitals, Al-Hamadi found, using a correlational analysis of survey responses, that job performance is positively correlated with organizational commitment, job satisfaction, and personal and professional variables. Both job satisfaction and organizational commitment were found to be strong predictors of nurses' performance. Job performance was positively related to some personal factors including years of experience, nationality, gender and marital status. Level of education, however was negatively related to performance. Implications derived from the study suggested the need for effective supervision, empowerment, and better reward systems. Al-Hamadi also added that because cultural diversity is a reality for most health organizations in Saudi Arabia, they need to adopt effective human resource strategies that aim to improve commitment and retention of qualified workers and build a high performance organisational culture based on empowerment, open communication, and appreciation of the impact of national culture on work attitude. A more recent epidemiological study using a cross-sectional approach and a convenience

sample of 637 nurses in Eastern Saudi Arabia revealed that variables having significant predictive effect on the performance of nurses in secondary health care were stress ( $p = .016$ ), shifts( $p = .010$ ), and department of work( $p = .032$ ) (Al-Makhaita, Sabra, Hafez: 2014).

Similarly, Ng and Feldman (2010) conducted a meta-analysis on organizational tenure and job performance inclusive of 350 empirical studies with a cumulative sample of 249,841. The authors reported that employees with longer tenure generally have greater in-role performance. Organizational tenure was also found to be positively related to counterproductive behaviour like aggressive behaviour, and non-sickness absence. These things may also be a major challenge in Saudi Arabia and will be explored in the research. A better performance and better outcome of healthcare delivery of health organizations depend largely on knowledgeable, skilled managers which can motivate workers and address insufficient number and properly delegate staff on health services. It is, therefore, necessary for employers to provide suitable, flexible, and culturally acknowledged working conditions to ensure that workers display a desirable performance that aligns with the desired standards of care (CBAHI Standard 2012).

It was noted from the above literature that organizational, professional and personal variables contribute to nurses staying longer with the employer. This also implies longevity in the workforce and suggests that the employee is satisfied in the job and that the work environment is also conducive to this satisfaction. Thus, it could be said that job satisfaction contributes to good performance. This claim is supported by the study made by Adams and Bond (2001) who looked into the relationships between aspects of the organization of acute hospital wards, nurses' personal characteristics, and nurses' job satisfaction among 834 nurses in England, representing a national sample. The authors reported a positive association between interpersonal relationships and job satisfaction. Other influential factors are nurses' relationship with medical staff, perceptions of their workloads and their evaluation of the appropriateness of the system of nursing being practised. Relative to this, Kettle (2002) pointed out that job satisfaction in staff nurses should be of great concern to any organization because the nurses hold the majority of positions in most health care settings, and that replacement and recruitment of licensed personnel is costly and time consuming. Therefore, perception of workloads and evaluation or performance appraisal were

deemed important by the researcher to research in this work to come up with a comprehensive strategy designed to address the needs of the health practitioners.

A further result identified by Al-Hamadi, (2009) relating to job performance is that of the effect of staffing levels. This was supported by DeLucia and Ott (2010), who stated that shortage of nurses and inefficient staffing result in task overload for nurses. As a consequence, nurses work long shifts and often without breaks. There is also excessive emphasis on completing documentation, waiting for results and searching for information. Completion of these tasks results in a lesser time spent on patient care and monitoring and thus affect the performance of nurses.

One study was conducted by Yaghoubi, Javadi, Rakhsh and Bahadori (2013) in selected hospitals of Isfahan, Iran. The performance achievement model they used has seven factors and these are ability, clarity, help, incentive, evaluation, validity, and environment. In total, 85 nurses from 9 hospitals participated in the study. The investigation showed that nurses who had more job experience (over 25 years) gave the highest scores to *motivation*. Those with post-graduate education gave the highest scores to *ability*. The male nurses gave the highest scores to *help*. The factors reported to affect performance of nurses were ability and help, with the highest mean scores, while clarity and validity had the lowest mean scores. This study further revealed that there was a significant relationship between performance and gender; between performance and job experience; and between performance and level of education. There was no correlation found between performance and age. Ability and help were found to be the most important factors in improving performance of nurses while validity and evaluation were found least important.

A similar study by Safei and Haryanti (2011) explored the factors affecting nurse work performance in an inpatient unit of RSUD Kota in Tanjung Pinang City, Malaysia. Using quantitative non-experimental cross-sectional study design and a sample of 82 nurses implementing inpatient installation, the researchers found the hope factor to be moderate (70.7%) and the supervision factor to be moderate (87.7%); motivation and incentive factors were high (98.8%); environment and tool was high (89.0%); and knowledge and skill was moderate (70.7%). However, according to the authors, hope in the job was the dominant factor affecting the performance of the nurse.

Dimabayao (2002) in a study in Saudi Arabia on aspects affecting job performance identified shortage of nurses as a very serious problem. Other issues were salary rate, attendance of other health teams, language barriers and cultural differences. However, Dimabayao noted that knowledge of the job, doctors and nurses' working relationship, and routine of work were not serious issues. Language barriers and cultural differences were expected to be identified as problems among the nurses because most of them are expatriates. However, although the English language is commonly used by the staff in the hospitals, patients or clients tend to use Arabic.

Work performance can affect quality of life; therefore, Almalki, Fitzgerald, and Clark (2012) assessed the quality of work life among primary health care nurses in the Jazan region, Saudi Arabia. It was a cross-sectional, descriptive study using Brook's survey of quality of nursing work life and demographic questions. The study demonstrated a response rate of 91% of the total nurses ( $n = 532/585$ ) in 134 primary health care centres in Jazan region participating in the study. They revealed that the nurses were dissatisfied with their work life. The major influencing factors were unsuitable working hours, lack of facilities for nurses, inability to balance work with family needs, inadequacy of vacation time for their nurses and families, poor staffing, management and supervision practices, lack of professional development opportunities and an inappropriate working environment in terms of the level of security, patient care supplies and equipment, and recreation facilities (break area). When the demographic variables were considered in determining the quality of work life of the nurses using *t*-test and ANOVA, the authors found that all the *p*-values were lower than the *t*/*F*-values. This meant that quality of work life among the nurses were not different in terms of gender ( $t/F = -3.11$ ;  $p = 0.002$ ); in terms of age ( $t/F = 10.46$ ;  $p = 0.000$ ); marital status ( $t/F = 6.49$ ;  $p = 0.002$ ) and dependent children ( $t/F = 3.1$ ;  $p = 0.002$ ). This aspect of work life will be further explored in this study.

### **2.3 Performance Management**

Performance management is a key component of supporting the necessary dignity, respect, compassion, and patient-centred care in the nursing profession (McSherry et al., 2012). To support these elements of nursing performance and to instil public confidence in the profession it is necessary for nursing leadership and educators to collaborate in supporting improvement in quality

of care and the social image of nursing (McSherry et al., 2012). When examining work performance and work conditions, the key concept is performance management, or the management of knowledge, work performance, and the impact of these on patient care (Currie et al., 2008).

Research has provided evidence in support of the positive effect of performance management on nursing performance at the organizational and individual levels, ultimately supporting improved quality of patient care through improved performance (West, 2001). In a study on performance management, West (2001) translated performance management research from a variety of fields to the health care field, suggesting the importance of decentralized decision-making, staff participation and involvement, innovative work practices, and alignment of structure, strategy, and environment. In addition, adding to the conclusions of West (2001), Smith (2002) described the use of business models of performance management in the British National Health Service, which offered the prospect for major improvements in quality of care. Smith also noted the requirements of information, leadership, and managerial resources to support adequacy of performance management.

Tuan (2013) conducted an investigation that included performance management in other countries. Using structural equation modeling to analyse 349 survey responses from a hospital middle management. Results supported the role of clinical governance and knowledge sharing in performance management in healthcare (Tuan, 2013). Leadership support for complex reform through management, education, empowerment, encouragement, and resource management of staff toward innovation in practice is critical to ensuring nursing excellence (McSherry et al., 2012), supporting the importance of these elements to this study. Accordingly, to demonstrate nursing excellence healthcare organizations require shared working partnerships supporting collaboration between nurse managers, leadership, and educators and the organization (McSherry et al., 2012). Also highlighting responsible leadership, Tuan (2013) found ethical corporate social responsibility (CSR) to support clinical governance in healthcare service organizations, through knowledge sharing practices. This is important to this study because through driving CSR, clinical governance influences the quality of patient care service. In an examination of 417 responses from self-administered questionnaires from clinical staff members in Vietnamese hospitals, Tuan (2014)

found CSR to be a strong predictor of effective clinical governance, yielding high quality patient care and affecting brand equity of the hospital. Tuan (2014) concluded that high levels of CSR support the clinical governance mechanism, which, in turn, support quality through implementation of initiatives for improved patient care and service quality. Excellence in nursing stems from authentic and sustainable leadership that supports innovation and reform, allowing nurses to provide safe, compassionate, quality care (McSherry et al., 2012).

## **2.4 Stress and Burnout among Health Workers**

A further consideration in relation to work performance is that of stress and burnout. When this happens, performance is affected and the quality of care provided to the patient is likewise affected. This is shown in the study by Harvey et al. (2004) in 20 urban hospitals in the United States. Their study revealed that the overall level of nurse burnout on hospital units affected patient satisfaction. They attributed this to the shortage of staff nurses. To overcome this, they recommended improvements in nurses' work environment.

Burnout, as defined by the seminal work by Maslach (1982), describes the emotional reactions of staff whose work involves continual exposure to emotional and physical stress. Paine, (1984) pointed out that burnout is progressive deterioration in work and other performance resulting from increasing difficulties in coping with high and continuing levels of job-related stress and professional frustrations. According to Duquette et al (1994) after analysing 300 documents on nursing burnout, they were able to select and classify correlates of this condition. These are role ambiguity, workload, age, hardiness, active coping and social support which reflects the issues identified in the research discussed in Section 2.

That the situation has not changed is suggested by the findings of Lin, St. John and McVeigh (2009) survey conducted among 128 out of 249 randomly selected nurses in Peoples Republic of China using a translated version of the Maslach Burnout Inventory-Human Services Survey. Their study revealed that hospital nurses in China experienced higher levels of emotional exhaustion when they were older ( $p < .001$ ), married ( $p < .014$ ), worked in a higher position ( $p < .003$ ), and had a higher professional title ( $p < .019$ ). They further established that nurses with more responsibilities were more prone to emotional exhaustion. Nurses with greater support from

colleagues, managers and friends experienced lower levels of burnout, which suggests that social support is a buffering factor to burnout.

Another study on burnout by Lasebikan and Oyetunde (2012) in a Nigerian General Hospital also used Maslach Burnout Inventory where 270 out of 292 (92.3%) nurses participated. Their study revealed that older nurses ( $p < .01$ ), female gender ( $p < .01$ ), being unmarried ( $p < .01$ ), junior nursing hierarchy ( $p < .01$ ), nurse-doctor conflict ( $p < .01$ ), and too frequent night duties ( $p < .01$ ) were significantly associated with high burnout. It can therefore be suggested that burnout among nurses is influenced by the work environment.

Aside from burnout, Lu, While, and Bamball (2005) pointed out that the current nursing shortages and high turnover is of great concern in many countries because of its impact upon the efficiency and effectiveness of any healthcare delivery system. The authors argued that recruitment and retention of nurses are persistent problems associated with job satisfaction. This prompted them to recommend a good model incorporating organizational, professional, and personal variables in the development of interventions to improve nurse retention. The present study would also consider these elements in the proposed strategic plan to address the factors affecting work performance of health care practitioners in the Jazan region as it can be suggested that developing the performance of nurses who are satisfied in the job is a better option than replacing them with new nurses.

## **2.5 Impact of Education on Work Performance**

According to Sperry (2003), healthcare managers play an indispensable role in boosting productivity, quality care, and cost savings as well as patient and employee satisfaction. These can be attained if healthcare practitioners are equipped with the necessary education and training for the job. Increased attention to factors that promote quality and safety of patient care along with nurses who are caring and committed with critical thinking skills can aid in increasing patient and employee satisfaction (Rush and Cook, 2006; Simpson, 2002; USIM 2003).

Continuing education opportunities can affect work performance and satisfaction. Reviewing the profiles of healthcare practitioners employed in Jazan will indicate their educational background and the training they have had and presupposes that their knowledge and skills meet current trends and that practices in their field are appropriate and will offer a starting point for future educational

development opportunities. This view is supported by Alkhazim and Althubaiti (2014) in their quantitative study on continuing medical education (CME) in Saudi Arabia, which showed the importance of improving competencies of medical workers. With 601 participants in their survey, (36.1% of which were nurses), using a questionnaire containing 24 items where respondents indicated agreement or disagreement to statements, results revealed that 85.3% agreed with CME in that it is effective at improving clinical and academic skills and 82.5% disagreed, stating that CME was a waste of time. The results maybe attributed to education, training, and practice in the country of origin; the authors stated that the healthcare practitioners acknowledged the importance of CME in improving knowledge, attitudes, and clinical and academic skills, as well as their clinical practice outcome (Alkhazim and Althubaiti, 2014). Therefore, this proposed study would also include continuing education as one activity to explore in addressing the factors influencing the work performance of healthcare practitioners in Jazan.

A similar study by the project author and his colleagues (Al-neami, Dimabayao, and Caculitan, 2014) reflected this when looking into the competencies of 40 nursing interns during the Academic Year 2013-2014 at King Fahd Central Hospital in Jazan, Kingdom of Saudi Arabia. The development of competencies was measured from the start of their training using a questionnaire and re-measured six months into their training. Results showed that their competencies from the start were “Fair” and improved to “Good” during their training. Analysis using *t*-test statistical analysis approach showed a significant difference in Knowledge and Skills, but not in Attitudes, based on the comparison between the computed *t*-values and critical values on a 0.05 alpha level. This finding suggests that competencies of nursing interns are not yet well-developed as they start their training. Hence, it was recommended that teamwork, collaboration with institutions offering nursing programs, and revisiting the MOH Nursing Competency Program of KSA (2011) can bring out a better training and competency development among nursing aspirants. In the light of this recommendation, it also implies that advanced education and forms of continuing education are seen important to provide further training and development of nurses. These will upgrade their knowledge and skills to be highly competitive at all times. Education is a very effective strategy in developing further knowledge and skills of any professional.

In all healthcare organizations, productivity and good performance of a healthcare provider ensures that health interventions are delivered efficiently and competently. According to Sperry (2003),



health care managers play an indispensable role in boosting productivity, quality care, and cost savings as well as patient and employee satisfaction. These can be attained if health care practitioners are equipped with the necessary education and training for the job. Relative to this, the US Institute of Medicine (2003) through their article on health professional education, stressed the need for increased attention on factors that promote quality and safety of patient care. Rush and Cook (2006) also pointed out the two extremely important attributes of an ideal nurse, which include having a caring nature and serving people whole heartedly.

These issues affect all nurses working in Saudi Arabia; however, the expatriate population may face other issues in their workplace as well as these. Considering the fact that many of the health practitioners in the Kingdom of Saudi Arabia are expatriates (Pallot, 2011; Simpson, 2002), there are problems that they encounter about conditions in the workplace, incentives, and problems affecting their work performance aside from socio-cultural dimensions (Almalki, Fitzgerald, Clark, 2012). Alongside with this are differences in organizational structure and policies in health care facilities, which are brought about by the form of government where the study is to be conducted. As noted by Berhie (1991), there is an acute shortage of indigenous trained healthcare providers in Saudi Arabia. This situation has not been addressed as gleaned from the report made by Al-Mulhim (2013: 1), in which the author claimed,

*‘Saudi health system is very dependent on expatriates who work in Saudi Arabia as we still need more Saudis and expatriates to staff the medical centres and hospitals.’*

Al-Mulhim also stated that having large number of foreign medical staff from different cultures makes it important to address specific staff needs in order to achieve efficient health care delivery. These things continue to be a major challenge in Saudi Arabia. It is therefore important for employers to provide a suitable, flexible, and culturally acknowledged working conditions to ensure that workers display a desirable performance that coincides with the desired standards of care. Along this premise, this proposed research will investigate the role of employers in healthcare in Saudi Arabia in supporting their staff.

## **2.6 Quality, Nursing Management and Leadership**

The conditions and problems cited above can be best addressed through the health care managers. It is for this reason that the present study included the health care managers as a source of data.

Implementation of policies and staffing are within their functions. Because the main focus of this study is to determine the factors affecting performance of nurses, considering the management skills and leadership of health care managers is necessary. In addition, these managers also will be involved in the recommendation of nurse staffs to undergo training and development through continuing education.

The role of health care managers is important in the organization. The efficiency and effectiveness of the organization in providing services can be traced from the quality of management and leadership they practise. Anderson (2013) stressed the difference between nurse leadership and management. The author stated that a leader often does not have delegated authority and, rather, focuses on empowering others, motivating, inspiring, and influencing others. In contrast, she stated that a manager is expected to carry out specific duties and has definite responsibilities; has control over process and decision making.

It can be gleaned from the above statements that there are distinctions between leadership and management. However, there can be instances where roles may overlap. This happens in an individual who possessed the characteristics of both. With this, Anderson (2013) further noted that all nurses are leaders and managers at some level. By this, she meant that nurses should strive for a balance between doing the right things and doing things right. Thus, this leads toward a productive and efficient unit in the healthcare facility with satisfied personnel. This claim is supported by the study by Despres (2011). In her dissertation, Despres used a sample of 83 full time medical surgical intensive care nurses in two hospitals in Phoenix, Arizona, USA. Analysis of the completed Job Description Index for Jobs in General and the Multifactor Leadership Questionnaire accomplished by her respondents showed a significant, positive correlation between job satisfaction and perceptions of nurse managers' leadership style by nurses. A synonymous finding was revealed by Cummings et al. (2010) in their analysis of 53 studies screened from 34,664 titles and abstracts on leadership styles and outcome patterns for the nursing workforce. Of the 53 studies, 24 reported that leadership styles focused on people and relationships were associated with higher nurse job satisfaction, whereas 10 studies showed that leadership styles focused on tasks were associated with lower nurse job satisfaction.

The two studies (Despres 2011, Cummings et al 2010) on leadership styles practiced by nurse managers showed that leadership styles proved to be associated with job satisfaction. However, these studies did not include whether or not the leaders are new in that designation. The study made by Baxter (2013) conducted among nurse managers in two medical centres in Kentucky clarified the results using the Nurse Manager Skills Inventory Tool and the Learning Domain Framework. Data collection resulted in return rates of 89% (n=16, N=18) and 44% (n=21, N=48) for the two centres. After analysing the responses of the two samples, Baxter deduced that the nurse managers perceived themselves as competent up to six years and being proficient up to nine years on the skills listed in the inventory. This meant that good leadership skills are not manifested by managers from the start in the performance of their role. However, teamwork of all health care providers can bring about a successful performance. This instance was expounded by Ward (2013), who said that when nurses function as part of a unit and when they act as part of team, the job itself is easier and more efficient. Most importantly, overall patient care is enhanced. This can happen when a healthcare facility is well-staffed and with adequate resources and equipment needed in the work. A shortage of any of these can create a lower level of performance and thus affecting motivation and the quality of healthcare.

It is not only nurse management and leadership that affect staff performance. There are also environmental factors, as revealed by Edwards (2011) in the Midwest area of the United States. These environmental factors contribute to nurse dissatisfaction resulting in nurse turnover. Hence, she pointed out that nursing leaders and nursing management make changes that may enhance nurses' satisfaction and retention. Staffing was a significant problem identified in this study.

Work environment-related factors can be internal or external, as was the focus of the study by Hoh, Kwon, and Hwang (2011), who determined the internal and external environment factors affecting performance of hospital-based home nursing care in Korea. They included all the 89 training hospitals that were practising home nursing care (HNC). After analysing their data using multiple linear regressions, they found that both internal and environmental variables had significant effects on the HNC based on univariate analysis. However, internal environment factors were found more meaningful compared to external factors. Specifically, managerial resources (the number of operating beds and the outpatient/inpatient ratio) were found meaningful when multiple linear

regression analysis was performed. This indicated that these problems should be addressed if quality and effectiveness are desired.

Work of Young et al (1981), although from over 30 years ago , indicates that when there is a shortage of staff, work schedules and load become heavy which is one cause of stress in the workplace. However, Young et al (1981) noted that studies of the interrelationships of these factors have been ignored. Furthermore, team nursing, use of computers as it affects nursing schedules, and the unit dose system were among the environmental factors to affect nursing care that were discussed in the literature they reviewed. More recent research (Alamlki, Fitzgerald, and Clark 2012; Lu, White, and Bamball, 2005.) indicates these issues have not changed. These studies also revealed that scheduling and the modified work week were among management factors contributing to the problem. These continued findings imply that such problems have existed since the 1980s and although solutions were made to address the problems, they continue to persist due to changes of policies of the company or the state, practices and changes in the management styles and leadership skills of hospital managers.

Much is expected from management styles and leadership skills of hospital managers and even from nurse supervisors regarding work performance of nurses. This prompted Safei and Haryanti (2011) to explore the factors affecting nurse work performance in inpatient unit of RSUD Kota in Tanjung Pinang City, Malaysia. Using the quantitative, non-experimental (observation) with cross-sectional study design with a sample of 82 nurses implementing inpatient installation, the researchers found that hope factor was moderate (70.7%); supervision factor was moderate (87.7%); motivation and incentive factors were high (98.8%); environment and tool was high (89.0%) and knowledge and skill was moderate (70.7%). When correlations were treated, it turned out that hope in the job was the dominant factor which affects the performance of the nurse.

Accordingly, in any work organization, employees expect some forms of assistance or technical guides in order to perform well. This is what Safei and Haryanti (2011) mean by “hope in the job”. It is the belief by the employee like a nurse that certain actions are to be executed after certain results are given. This includes performance appraisal, presence of professional standards and clear responsibility as reflected in the job description.

As a consequence to the above situation, Awases (2006) stated that health systems are not producing the desired output of health interventions due to factors such as insufficient skilled and experienced health personnel, demotivated health personnel, lack of management skills, poor working conditions and environment and inadequate remuneration. Because of these conditions, Awases explored the factors that affect performance of nurses in Namibia with the aim of providing a management framework for improving the performance of professional nurses. She used a quantitative approach with an explorative descriptive design. The reaction to the study was positive as evidenced by a response rate of 75.8% of professional nurses in Oshana, Otjozondjupa and Khomas regions in Namibia. When data were analysed, it was revealed that hospitals currently have deficiencies in human resource management aspects, such as recognition of employees who perform well, working conditions, implementation of performance appraisal systems, feedback of performance outcomes and management skills. These aspects were found to be strongly associated with the level of performance of health personnel. The management framework she proposed consisted of activities for enhancing the nursing profession; strengthening knowledge and expertise, including management skills; improving performance; and generating knowledge through research. These recommendations will be utilised in the present study.

As identified by Awases (2006) demotivation of health personnel is one of the causes of not attaining the desired job performance. Omprommorat and Sriruecha (2013) investigated motivation factors affecting the performance of 190 village health volunteers in non-communicable disease control selected through systematic random sampling in Huang Thalaeng District, Nakhon Ratchasima Province. Results of the study using normative statistical analysis showed that motivation to work had a mean of 2.48, which showed that it was on a high level. Their level of performance was also a high level with a mean on 2.56 and this was accounted to 82.6 % of the total respondents. The investigators found out that variables that potentially predict high performance of the health volunteers were job security, factors in personal life, length of stay in the operation, working conditions, and income. There were also problems and obstacles found to affect their performance and these were associated with equipment and inadequate fringe benefits.

Another study focused on motivation was done by Noori, Dehghani and Rajaei (2014), who examined the nurses' and midwives' health-motivational needs affecting their performance. This was conducted in Shahid Beheshti Hospital in Isfahan (Iran) in 2013. Their study population and inclusion criteria were all nursing and midwifery staff (supervisors, nurses, midwives and health workers) who had at least one year of experience and had not any diagnosed diseases. Through the researcher-made questionnaire, they found out that regarding motivational needs, in descending order, the priorities were on areas of growth or development through education, gratitude, success, and responsibility. With regard to health needs issues of interpersonal relationships, workplace conditions, nature of the work, salary and benefits, equipment, and management policy were given priorities in that order.

Finally, a study that used tools to explore recognition as factors affecting work performance was done by Fort and Voltero (2004). They explored how factors, individually as well as in combination, affect the performance of primary reproductive health providers (nurses and midwives) in two regions in Armenia. There were 285 nurses and midwives who were observed conducting real or simulated antenatal and postpartum/neonatal care services. They were interviewed about the presence or absence of the performance factors within their work environment. Baseline results revealed that performance was sub-standard in several areas and several performance factors were deficient or non-existent. Multivariate analysis showed that (a) training in the use of clinic tools ( $p < .01$ ); and (b) receiving recognition from the employer or the client/community ( $p < .01$ ) are factors found as strongly associated with performance, followed by (c) receiving performance feedback in postpartum care ( $p < .05$ ).

In summary the main issues evolving from the literature in relation to staff performance include personal or demographic-related factors, such as length of time in job, stress and burnout, motivation, quality of life issues, and education and development opportunities. Further issues related to work environment were also identified, such as staffing levels, rostering, salary, and management styles.

## **2.7 Strategies to Improve Work Performance**

After identifying the factors affecting work performance of healthcare workers particularly nurses, the researcher also wants to develop strategies on how to address them. Hence, this is the ultimate goal of the study. This is why literature on strategies to improve work performance was included in the review.

Ruder (2013) described strategies to improve the work environment of professional nurses working at a private hospital in Bloemfontein in South Africa. She started her investigation by analysing the current situation within the subject hospital by using the Nominal Group Technique. Characteristics of a negative and a positive work environment were identified and the benefits of creating and maintaining a positive work environment were established and highlighted. Recommendations she gathered during the nominal group sessions were categorised and prioritised to ascertain the most important and critical factors that could improve the work environment of professional nurses. What was unique in her work was that the strategies were formulated based on the recommendations provided by the nurses themselves, which they believed would improve their work environment. In addition, the strategies that were organised could be used by the management of the hospital to improve the work environment of the professional nurses as well as to retain the existing staff and to the recruitment of new candidates to fill vacant positions.

Hassmiller and Cozine (2006) cited a report of the Institute of Medicine that the quality of care for hospital patients is strongly linked to the performance of nursing staff. Hence, their paper described the Robert Wood Johnson Foundation's (RWJF) work in nursing, which focused on improving the hospital work environment to attract and retain high-quality nursing staff, with the ultimate goal of improving patient care and outcomes in hospitals. They also explored the efforts of other organizations to address the shortage of nurses. According to Hassmiller and Cozine, to attract high-quality staff, to enable them to do their best work, and to keep them as long-term employees, improvement must be made in the organization of work and use of information technology (IT); physical design and allocation of space; and hospital leadership and culture.

A different approach was presented in the study by Lucas (2014). She identified the opportunities for employers to use high-fidelity, simulation-based learning programs to promote continued competency and confidence among practicing nurses. Lucas stated that practicing nurses are expected to adapt by independently acquiring new clinical knowledge through experience and independent study. However, she noted that health care institutions have tried to provide quality patient care and supporting nurses' learning through experience simultaneously. Hence, she is recommending the use of high-fidelity simulation-based learning, which addresses this need by providing no-risk experimental learning that expands skills without jeopardizing the safety of patients.

In the same year, Sherman (2014) discussed the strategy of improving the performance of nursing workforce through the analysis of generational cohorts and their differences by taking them as potential strengths. Health care institutions are composed of workforce with generational diversity. Generational diversity illustrates a workforce with differences in attitudes, beliefs, work habits, and expectations. She cited Zemke (2000) about the description of generational cohorts as groups of people who share birth years, history, and a collective personality as a result of their defining experience. Thus, leaders in institutions may use generational differences in enhancing quality of productivity, motivating, reducing conflict, and maximising contributions of all staff.

Kubica and LaForest (2009) articulated their strategy to maximize healthcare department performance. A preliminary step in their strategy is a set of questions serving as trigger for maximizing performance. These questions ask whether there are departments within the organization performing within the expectations; and whether there is a succession plan for key department leadership positions. In the light of these two questions, they suggest that to improve performance the following issues are considered: recruiting and retaining department leaders; transitioning managers into their new position; departmental succession planning; managing departmental growth; improving service; improving financial/budget performance; improving overall performance; improving the performance of the team or of a key employee.



## **2.8 Theoretical Background of the Study**

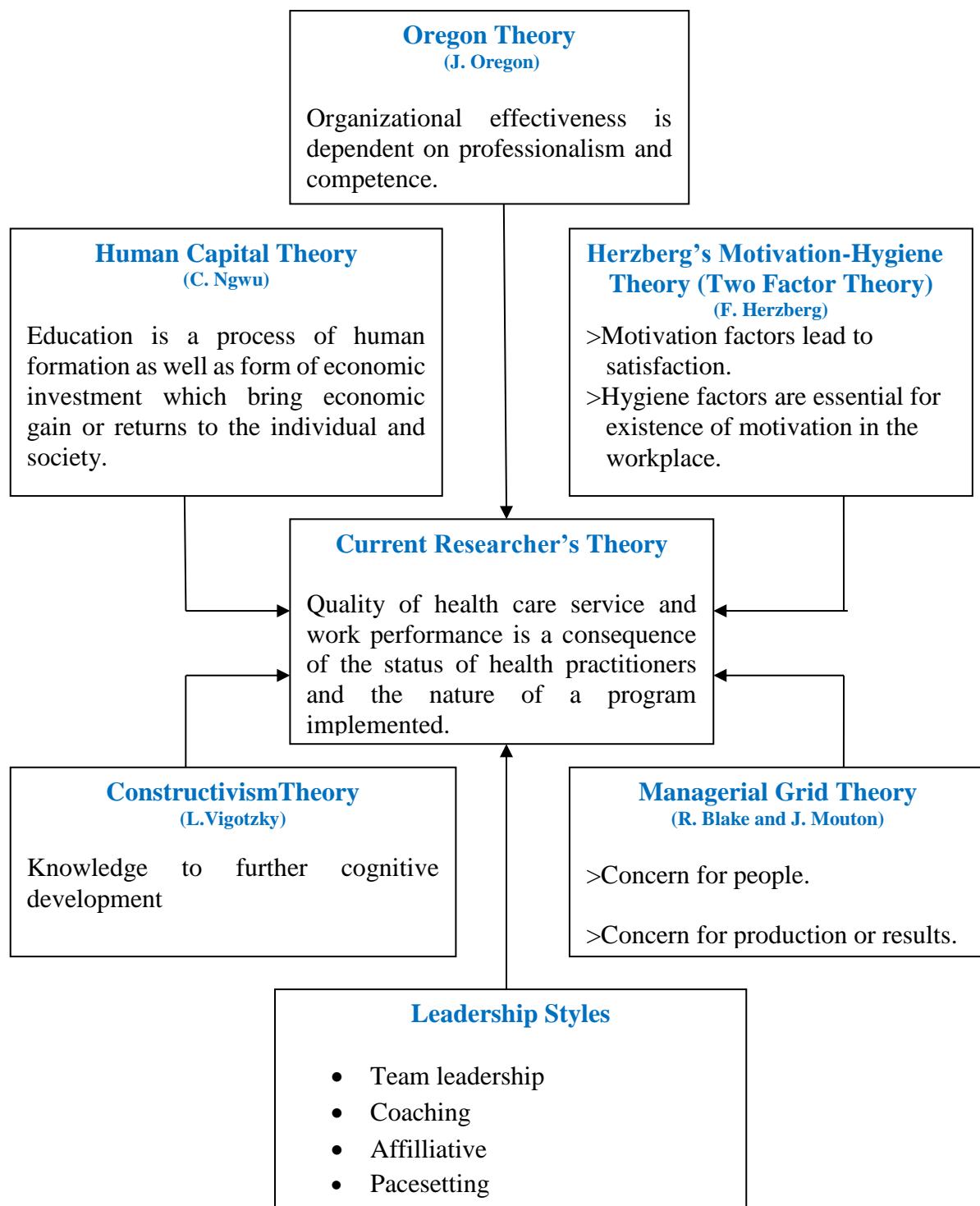
The researcher had in mind that if employees, like health practitioners, are assessed as to their profile and work performance and that whatever weaknesses found from them are given proper and appropriate solutions, these health workers would provide better performance output. Hence, satisfaction is attained by them as well as the clients to which they give their services. With this as a premise, this section presents six theories, which would support the research proposed.

### **2.8.1 Theoretical considerations**

Theories provide strength on the significance of the study. According to Subong (2005), a theory refers to an organized body of knowledge or a set of propositions that is firmly grounded on a series of observed phenomena, events, and empirical data that are duly supported by the thinking of well-known authorities on the subject. Along this premise, the researcher believes that the quality of health care services delivered and work performance is a consequence of the status of health care practitioners and the nature of a strategic plan implemented.

The literature reviewed offered a profile of health practitioners, their problems and factors affecting work performance. The studies reviewed in this literature review provided insight into the variables that affect nursing work performance. Each research study or article reviewed stood differently from the other. However, they produced similar results that could be explored in the current research in trying to find out which factors affect work performance so that appropriate solutions could be made.

Since the ultimate objective of this study is to develop a strategic plan that would eventually improve work performance of health practitioners and delivery of health services as well, there were theories considered to support the belief of the researcher. Each theory is presented and how it supports the study indicated. To help illustrate the theory of the researcher, the paradigm of the theoretical framework is shown Figure 1.



**Figure 1. Paradigm of the Theoretical Framework**

### **2.8.1.1 Oregon Theory (Oregon, 1989).**

This theory states that organizational effectiveness is dependent on professionalism and competence. On one hand, professionalism is the act of the professional which requires intellectual character, a substantive degree of judgment in the performance of work required from extensive education and training, as well as experience in the application of skills. On the other hand, competence as the basic drive for effectiveness is one that motivates a person, enabling him to be active, to explore, and to deal effectively with the environment. Furthermore, competence includes abilities, motives, traits and skills, and personal attributes that are related to effective behaviour.

This theory is applicable in this study because the health practitioners will be provided with continuing education, aside from recommending them for advanced education. In this sense, the professional growth they will acquire through continuing and advanced education is instrumental to the development of competence. They will also acquire knowledge on the current trends and practices in the profession and will, therefore, be more competitive. When professionals, like the health care practitioners in this study, are competent, they become more effective in terms of their job performance. Consequently, this competence will increase patient or clientele satisfaction.

### **2.8.1.2 Human Capital Theory (Ngwu, 1989).**

By definition, human capital is the accumulated knowledge and skills that make a workforce productive (American Heritage Dictionary of the English Language, 2011). In economics, the word is used to describe the abilities and skills of any individual, especially those acquired through investment in education and training, that enhance potential income earning (Harper Collins Publishers, 2003). Human capital theory as explained by Marshall (1998) is a modern extension of Adam Smith's seminal explanation of wage differentials by the so-called net (dis)advantages between different employments. The costs of learning the job are a very important component of net advantage and that other things being equal, personal incomes vary according to the amount of investment in human capital; that is education and training undertaken by individuals or groups of workers.

It could be gleaned from the statements above that this theory considers education as a process of capital human formation as well as form of economic investment, which brings economic gains or

returns to the individual and society. Apparently, education is highly essential to the development of the productive capacity of humans. Thus, the improvement of a productive capacity of the human workforce is a form of capital investment.

This theory works well in this study because the strategic plan is designed to improve professional status as well as work performance of the health practitioners. Those who will be found in need of further education and training will be extended the opportunity to undergo professional growth, either through advanced education or continuing education. Obviously, these forms of professional growth require money as capital considerations to realize them. When these health care practitioners complete the training/education, the benefit they receive is an upgrade of educational attainment or qualification, which consequently means an increase in remuneration or salary. Because they are assumed to have been equipped with better knowledge and skills, they will provide better performance to enable a higher satisfaction level from the clientele.

Both the Oregon theory and human capital theory support continuing education and advanced studies as form of professional growth. As it was noted in the educational qualification of the health care practitioners, most of them have finished a course lower than a baccalaureate degree. Hence, the knowledge and skills they acquired is commensurate to the work designation given to them. Such designation has also become the basis of their salary. Upon completion of their advanced education or continuing education, their present knowledge and skills has improved. As such, they would be giving better quality of health care services and increasing patient satisfaction as well.

#### **2.8.1.3 Constructivism theory of Vygotsky, (Vygotsky, 1978)**

Vygotsky espoused a seminal theory that suggested that culture is the principal determinant of cognitive process. His theory explains that knowledge leads to further cognitive development. This societal configuration of intelligence states that the individual growth could not be understood without indication to the societal and cultural context. Hence, Vygotsky's theory focuses on the actual mechanism of development. In this way, the roles of mediators are very significant. Mediators are the people who help the person to alter their environment. Mediators also refer to the use of certain tools within socially organized activity.

Similarly, Ozer (2004) discussed constructivism as a new approach in education, stressing that humans are better able to understand the information they have constructed by themselves. Accordingly, he pointed out that the constructivism theory is a social advancement that involves language, real world situations, and interactions and collaborations among learners. In this situation, the learners, who are the health care practitioners undergoing professional growth, are considered to be the central focus in the learning process.

Given the cultural and societal context of nursing in Saudi Arabia, and that most of the health care practitioners are expatriates; this aspect needs to be considered in the study. Through collaborations among their peers and supervisors who are considered mediators, they will be able to improve not only in understanding the language and culture but also on better ways of carrying out procedures and nursing practice.

#### **2.8.1.4 Herzberg's Motivation-Hygiene Theory (Two Factor Theory)**

According to Frederick Herzberg, there are job factors that result in satisfaction and dissatisfaction as well ([managementstudyguide.com](http://managementstudyguide.com)) in an employment setting. On one hand, Herzberg described that hygiene factors are those job factors that are essential for existence of motivation in the workplace. These do not lead to positive satisfaction for long term. However, if these factors are absent or non-existent in the workplace, they often lead to dissatisfaction. Thus, hygiene factors are those that, when adequate and reasonable in a job, pacify the employees and do not make them dissatisfied. The hygiene factors symbolize the psychological needs the individuals want and expect to be fulfilled, which refer to pay or salary, company and administrative policies, fringe benefits, physical working conditions, status, interpersonal relations and job security. On the other hand, motivational factors yield positive satisfaction. These factors are inherent to work. They motivate the employees for a superior performance. Motivational factors are referred to as satisfiers. These are factors involved in performing the job and the employees find these factors intrinsically rewarding. Motivational factors include recognition, sense of achievement, growth and promotional opportunities, responsibility and meaningfulness of the work.

This two factor theory works well in this present work because it looked into the appraisal of the health practitioners regarding their benefits, remuneration and recognition, staffing, staff development, and work schedule. It is an accepted fact that when employees are well compensated and their performance is recognized, they are motivated to work and perform better and harder. This is why job satisfaction can be observed in the workplace, eventually resulting in improved satisfaction of client.

#### **2.8.1.5 Managerial Grid Theory**

Because the present work also included health managers and their tasks, it was also seen important that discussions on management styles, as well as leadership styles, be a part of this chapter. It is because the health care managers must be able to recognize the potentialities and capabilities of health workers in the organization. Understanding their needs and problems will help in enhancing their performance for greater productivity in terms of health services. In this regard, the managerial grid theory by Blake and Mouton (1964, 1985) is very much applicable (). The grid clarifies the relationship between concern for people and concern for results or production in a 9-point scale. It plots the degree of task-centeredness versus person-centeredness. The proponents of this theory pointed out that a manager in a 1.9 scale is overly concern for people but low in concern for production. This means that the leader considers the needs of team members, their interests and areas of personal development when deciding how best to accomplish them. This position is illustrated in this present study, as there are provisions in the strategic plans on how to develop the health care practitioners like providing them with opportunities of continuing education and advanced education as well. Among the goals of this study is job satisfaction and to increase satisfaction of clients like the patients in health care facilities; therefore, the 9.9 scale is appropriate. It is because in this scale, the manager has high concern for people and equally high concern for job accomplishments or results. According to Blake and Mouton, this is the best managerial style because the leaders stress production needs and the needs of the people equally high. Furthermore, the proponents stressed that in this grid (9.9), the employees understand the organizations purpose and are involved in determining production needs. When employees are committed to, and have a stake in the organization's success, their needs and production needs coincides. Hence, a team environment based on trust and respect is created and this leads to high satisfaction and motivation. Because of this, high results are attained.

### **2.8.1.6 Leadership Styles**

With regard to leadership styles that best fit in the present work, particularly in terms of carrying out the strategic plan, the team leadership style is as a consequence of adopting a 9.9 scale in the managerial grid by Blake and Mouton. However, this could be supported by other leadership styles to bring better results. In an article by Murray from the Wall Street Journal Guide to Management (Murray, 2010), he presented the forms of leadership styles as explained by Daniel Goleman. Those ones found to relate to a good implementation of the strategic plan are coaching, affiliative and pacesetting.

In coaching, the leader takes a one-on-one style and it focuses on developing individuals. It goes further by showing them to improve their performance and helping them to connect their goals to the goals of the organization. Accordingly, this style works best with employees who show initiative and want more professional development. In this case, the goals and objectives set forth in the strategic plan would be possibly attained. Professional development of the health care practitioners is surely acceptable to them, because it provides them with better ways of performing their job. This is also a way by which the morale of employees is improved.

The affiliative style emphasizes the importance of teamwork and creates harmony in a group by connecting people to each other. Although health practitioners are already working as a team in the health setting, this is important to use in implementing the strategic plan. It is because there would be changes in staffing among others. Therefore, it is necessary that everybody is open to adapt to changes and they should be ready to implement the changes planned for development.

In pacesetting, the manager, as the leader, sets high standards of performance. He requires about doing things better and faster by everyone. Although this sounds to be autocratic, because the leader uses authority, it is seen to work in this study in the sense that one of the goals of the strategic plan is to provide the health care practitioners with education and training on current trends and practices in health care so that they are kept abreast with this in the global setting. This would not only mean the use of upgraded and modern facilities; it would also mean the acquisition of new knowledge and skills. All of these are instrumental in realising the vision of this research to provide

quality healthcare and services to all residents in kingdom irrespective of socio-economic status, faith and nationality.

## **2.9 Summary**

The literature review provided information on previous research related to work performance. This review highlighted the importance of proper management of human resources to the provision of quality care (Kabene et al., 2006) and that nurses' work systems often do not accommodate human limits and capabilities, forcing nurses to work under cognitive, perceptual, and physical overloads (De Lucia et al., 2009), suggesting that human factors should play a key role in the redesign of nurse work systems (De Lucia et al., 2009). Nursing job performance is positively correlated with organizational commitment, job satisfaction, and personal and professional variables (Al-Hamadi, 2009). In addition, job performance was positively related to some personal factors including years of experience, nationality, gender and marital status and negatively related to level of education (Al-Hamadi, 2009), suggesting the need for effective supervision, empowerment, and better reward systems. Al-Hamadi (2009) also added that because cultural diversity is a reality for most health organizations in Saudi Arabia, these organizations should adopt effective human resource strategies that aim to improve commitment and retention of qualified workers and build a high performance organisational culture based on empowerment, open communication, and appreciation of the impact of national culture on work attitude.

Organizational, professional and personal variables also were shown to contribute to nurses staying longer with the employer, implying longevity in the workforce and suggesting the importance of satisfaction and work environment to facilitating satisfaction (Adams & Bond, 2001). Employees with longer tenure have been shown to have a greater role in performance (Ng & Feldman, 2010). However, organizational tenure was also found to be positively related to counterproductive behaviour like aggressive behaviour, and non-sickness absence, factors that could be challenging in Saudi Arabia. A better performance and better outcome of healthcare delivery among health organizations, therefore, depends largely on having knowledgeable and skilled managers who can motivate workers and address issues related to insufficient staffing by properly delegating staff on health services. Thus, the literature supported the need for employers to provide suitable, flexible, and culturally acknowledged working conditions to ensure that workers display a desirable



performance that aligns with the desired standards of care (CBAHI Standard 2012). Therefore, nursing job satisfaction, inclusive of workloads and evaluation, is essential to sustaining the nursing staff, for which replacement and recruitment can be both costly and time consuming (Kettle, 2002). Nursing staffing insufficiencies can cause task overload for nurses and low job satisfaction, contributing to low performance (Al Hamadi, 2009).

Shortage of nurses remains a very serious problem related to job performance among nursing staff (Dimabayao, 2002). Other issues include salary rate, attendance of other health teams, language barriers and cultural differences.

Other factors have also been found to affect nurse performance. Hope in the job was found to be the dominant factor affecting the performance of the nurse (Safei and Haryanti, 2011). In addition, Yaghoubi et al. (2013) found a significant relationship between performance and gender; between performance and job experience; and between performance and level of education. Ability and help were found to be the most important factors in improving performance of nurses while validity and evaluation were found least important (Yaghoubi et al., 2013). Nursing burnout has been found to impact performance through correlates of role ambiguity, workload, age, hardiness, active coping and social support (Duquette et al., 1994). Burnout and emotional exhaustion are affected by age, marital status, professional responsibilities, and professional position/title (Lin et al., 2009), as well as gender, nursing hierarchy, nurse-doctor conflict, and frequent night duties (Lasebikan and Oyetunde, 2012). Conversely, nurses with greater support from colleagues, managers, and friends experienced lower levels of burnout, which suggests that social support is a buffering factor to burnout (Lin et al., 2009). Therefore, the literature suggests that burnout among nurses is influenced by the work environment.

The literature also supported performance management as a key component of supporting the necessary dignity, respect, compassion, and patient-centred care in the nursing profession (McSherry et al., 2012), which, in this context, is the management of knowledge, work performance, and the impact of these on patient care (Currie et al., 2008). Research has provided evidence in support of the positive effect of performance management on nursing performance at the organizational and individual levels, ultimately supporting improved quality of patient care through improved performance (Smith, 2002; Tuan, 2013; West, 2001). Leadership support for

complex reform through management, education, empowerment, encouragement, and resource management of staff toward innovation in practice is critical to ensuring nursing excellence (McSherry et al., 2012), supporting the importance of these elements to this study. Excellence in nursing stems from authentic and sustainable leadership that supports innovation and reform, allowing nurses to provide safe, compassionate, quality care (McSherry et al., 2012).

Increased attention to factors that promote quality and safety of patient care along with nurses who are caring and committed with critical thinking skills can aid in increasing patient and employee satisfaction (Rush and Cook, 2006; Simpson, 2002; USIM 2003). Continuing education opportunities can affect work performance and satisfaction (Alkhazim and Althubaiti, 2014). Given the acute shortage of indigenous trained healthcare providers in Saudi Arabia (Berhie, 1991; Al-Mulhim, 2013). Having large number of foreign medical staff from different cultures makes it important to address specific staff needs in order to achieve efficient health care delivery (Al-Mulhim, 2013). All nurses can be seen as leaders and managers at some level (Anderson, 2013), she meant that nurses should strive for a balance between doing the right things and doing things right. Thus, this leads toward a productive and efficient unit in the healthcare facility with satisfied personnel (Despres, 2011). Thus, leadership style has been shown to impact nursing performance (Cummings et al., 2010; Despres, 2011).

Related to leadership, work environment-related factors, both internal and external, impact nursing performance and satisfaction; however, internal environment factors were found more meaningful compared to external factors (Hoh et al., 2011). More specifically, managerial resources (the number of operating beds and the outpatient/inpatient ratio) were found significant, indicating that these problems should be addressed if quality and effectiveness are desired. These factors can affect motivation, another significant factor affecting performance (Awases, 2006 Noori et al., 2014; Omprommorat and Sriruecha, 2013). Therefore, the review provided insight into research examining strategies to improve work environments for nurses (Hassmiller and Cozine, 2006; Kubica and LaForest, 2009; Lucas, 2014; Ruder, 2013; Sherman, 2014).

Finally, the chapter discussed the theoretical foundations of the study. These theories serving to inform this research included Oregon theory, human capital theory, Herzberg's motivation-hygiene theory, constructivism, managerial grid theory, and leadership styles. These theories work

in conjunction in this study to help explain and understand the results. Using these theories, the researcher was able to construct his own theory to inform the research that helps to explain quality of health care service and work performance as a consequence of the status of health practitioners and the nature of a program implemented.

## **CHAPTER 3: METHODOLOGY**

**3.0** This chapter describes the methodology used in order to attain the aims of the study. Thus, the chapter provides a detailed discussion on how the data were collected and how the analysis of the data was completed.

### **3.1 Introduction and Background**

Determining the factors affecting the work performance of health practitioners as well as their needs to improve the same will provide the researcher the necessary information as to what strategies could be designed to address them. In other words, this objective will not only provide information about problems the health practitioners are encountering in the workplace, but also the factors that may contribute to these problems like performance appraisal and incentives.

The starting premise for this research has an expectation that all the health practitioners are qualified educationally and have gained the necessary training relative to their work as shown by their credentials during recruitment. The respondents' assessment on the workplace, and factors that influence their work performance were explored and analysed. Solutions may be developed from the research and once the issues are identified and addressed, it is anticipated that work performance will increase. Thus, results of this study would be beneficial to the health practitioners themselves, the managers of healthcare facilities, the Ministry of Health and the clientele of the healthcare facilities as detailed below

The health practitioners being the subjects of the study will primarily be benefited by the results of the study. Because issues relating to their work performance were examined, necessary and appropriate strategies to address these issues will be developed. These will not only improve their status as health practitioners, but hopefully, may relieve them of unnecessary forms of stress.

The managers of healthcare facilities will also benefit from this study, as they will be given feedback about the problems the health practitioners are encountering. Furthermore, they will be given a draft of the strategies to overcome such problems, thereby hoping to improve management practices particularly on human resources.

The Ministry of Health, being the major agency of the government in-charge with the promotion and administration of healthcare programs and policies in the kingdom, will be benefited by the results of this study for it will offer some solutions to address problems encountered by health practitioners. If such solutions are applicable in the Jazan region, it is also possible that it works in other regions.

The recipients or end-users of healthcare programs and interventions are the clientele. Once the solutions or strategies to overcome the problems are implemented, the clientele served by these healthcare facilities will experience higher satisfaction from the services. The study will result in presenting a strategic plan identifying and offering solutions to address any issues that are identified that maybe affecting the work performance of health practitioners. This is a very important facet of the study serving to realize the aim for which it was made. A strategic plan, according to Johnson and Scholes (1993) helps determine the direction and scope of an organization matching its resources to its changing environment and, in particular, its markets, customers, and clients so as to meet stakeholders' expectations. It is a way by which the desired future of healthcare facilities and health practitioners are envisioned in a systematic process. This involves translating the vision into broadly defined goals or objectives as well as identifying the sequence of activities to achieve them.

Given the current healthcare situation in Saudi Arabia, this study collected information about the status, conditions, and experiences of health practitioners of different races currently employed in health care facilities operating under the Ministry of Health in Jazan region, Kingdom of Saudi Arabia serving a approximate population of 1.5 million (MOH, 2010). The information to be gathered from them may shed light on their assessment of their workplace, incentives and the problems affecting their work performance as health practitioners. Hence, this is the aim this proposed study aims to undertake. Knowing and analysing their problems may contribute to the development and promotion of employee morale once they are addressed. Consequently, it may also raise the satisfaction level of patients in these health care facilities.

### **3.2 Aims**

This study aims to explore factors that influence health practitioners' performance. This knowledge would facilitate development of appropriate support and education for health care professions in delivering quality health care.

The Integrated and Comprehensive Healthcare (ICHC) in the Kingdom of Saudi Arabia laid down eight major initiatives. One of them is to develop human resources (Abulgami, 2013). Hence, the goals of the ICHC are geared towards quality, safety and satisfaction. These are attained through existing services of the facilities and the human resources. Thus, among the challenges faced by the MOH in the implementation of the goals of the ICHC are (a) performance measures; (b) manpower training and development; and (c) resistance to change. In view of the above, this study was focused on the following objectives:

### **3.3 Objectives**

The study was focused on the following objectives:

- A. To evaluate the profile of health practitioners and its implications to the delivery of healthcare services in the Jazan region.
- B. To explore factors that influence work performance and the needs of health practitioners.

### **3.4 Methodology**

Historically within the Kingdom of Saudi Arabia the positivist research paradigm is considered the only true research method. Thus any work that is undertaken is considered less worthy if it does not take this approach. However, for this work it was deemed important to not only gather quantitative data through a survey which would inform us about what the situation was at that point; but to also gather qualitative data from participants about why they considered these things to be of note. Bazeley (2004) argues that there are no exclusive or direct correspondences between these two paradigms and the methods and methodology that they use. Along with Lai and Waltman (2008) he suggests that the growing trend towards the use of mixed research methods allows a pragmatic model of research whereby validation of research findings is through data gathered by separate quantitative and qualitative means. One believes that the use of this

triangulation of data offers credibility to the findings by integrating multiple sources of data (Johnson et al 2007; Muskat et al 2012). This mixed method study uses a combination of quantitative and qualitative data collection methods in the form of a survey and semi-structured interviews to gain a breadth and depth of results and allow for clarification of points (Silverman, 2006).

As little is known about the research topic, the present study is an exploratory descriptive study using the quantitative cross-sectional method to gather relevant data and obtain a general overview of the health practitioners and qualitative semi structure interviews to establish perceptions from a sample of the research population. An exploratory descriptive study allows for the gathering of information from a subject where little is known about the topic (Polit et al, 2001). In addition, for a cross-sectional study, data are collected on the whole study population at a single point in time to examine the relationship between the variables of interest. Thus, the cross-sectional study allows the researcher to take a snapshot of the variables in a specific population at a certain given point in time. Cross-sectional research examines all study factors simultaneously, as noted; therefore, the outcome measure is prevalence, with continuous variables notably falling within a given range. The findings, however, are based on the numbers obtained during the specified timeframe (Institute for Work and Health, 2015). The benefits of cross-sectional research lie in the ability to compare different variables at the same time, such as age, gender, income, education level in relation to other variables of interest (Institute for Work and Health, 2015). Because this methodology can be used to assess the needs of a healthcare population, it can be useful in informing planning and allocation of health resources (Barratt and Kirwan, 2009).

Surveys can be conducted in a relatively inexpensive way and takes up little time to conduct, which is useful when there is a large number and location of participants as in this case. Estimation can be generated on prevalence of outcome and work performance can be assessed accordingly, which is useful for health planning (Levin, 2006; Shuttleworth 2008). Interviews allow for the collection of qualitative data that will illuminate and offer explanations for some of the survey results thus offering a more in-depth understanding of issues that affect health professionals and their work (Silverman 2006). Furthermore, the external audit as a form of inquiry audit will be used to

establish dependability (Lincoln and Guba, 1985). In this way, an external auditor will evaluate whether or not the findings, interpretations and conclusions are supported by data.

A descriptive cross-sectional study remains solely descriptive in nature and is often used to determine frequency and distribution of variables within a defined population at a specific time (Institute for Work and Health, 2015). The descriptive cross-sectional method was chosen because the study included two groups of health practitioners: the health workers and the health managers. This method is found appropriate because the study involves participants of various characteristics at the same point in time (Sevilla et al, 1992). These characteristics are age, gender, nationality, educational qualification and work designation. They will be taken from different health care facilities under the Ministry of Health in Jazan region.

### **3.5 Setting or Locale of the Study**

The choice of Jazan region as the setting of the study is due to its socio-demographic conditions presently happening as presented in Section 1.3 in the Introduction. Jazan region is the second smallest region of Saudi Arabia, but its urbanization is faster than other bigger regions. Furthermore, healthcare development also has been on the rise since 2012 (Rasooldeen, 2012).

### **3.6 Sampling and Data Collection**

#### **3.6.1 Sampling**

Selection of participants was accomplished through the non-probability sampling, particularly the purposive and incidental sampling techniques. Purposive sampling was used because the respondents were employed in the nursing department of health care facilities under the Ministry of Health and have the knowledge to answer the questions as they are health practitioners (Subong, 2005). Therefore, other paramedical units in those facilities were not involved. Similarly, incidental sampling was also used because the health workers and health managers in the nursing and medical category who were available and present during the collection of data were chosen (Subong, 2005). The sample included a total of 100 participants, 60 health workers and 40 health managers who are working in MOH facility in Jazan region.



### **3.6.2 Inclusion and exclusion criteria**

Robergs (2010) of the University of Mexico defines inclusion criteria as attributes of subjects that are essential for their selection to participate and are defined by a specific set of requirements that the participant must meet to be part of the study. On the other hand, exclusion criteria define those who are not eligible to participate. In this study, the following are the inclusion and exclusion criteria (see Table 1 below):

**Table 1. Sampling Plan**

Inclusion Criteria	Rational	Exclusion Criteria	Rational
<1 year of work experience	Adequacy of experience and already have performance appraisal.	Newly hired staffs	Experience is inadequate  And have no accomplished performance appraisal.
Charge nurses, head nurses, nurse supervisors, nurse managers, nursing deputy director and unit manager and physicians employed under MOH hospitals	They are in charge with a group of staff nurses and have leadership and management responsibilities	Staff nurses and other paramedical specialties such as pharmacists, lab technicians, etc.	Staff nurses are under charge nurses. Other paramedical specialties have no direct contact with patients.
Health workers and health managers working in a three-shift program	They have adequate experience on situations happening in 24 hours in the hospital.	Physicians and nurses working under Primary health Care Centres (PHCCs)	They do not work on a three-shift program.
Participants who voluntarily sign consent forms to participate in the program	For ethical reasons.	Health practitioners who did not sign the consent form.	They could not be compelled to give information or data.
Participants who speak and understand the English language well.	To be able to respond to the questionnaire and interview correctly.	Health practitioners who hardly speak and understand the English language.	It affects the pace in the collection of data.

It must be remembered that health workers in the nursing unit work on a three-shift program. Hence, the health practitioners working in the morning and afternoon shifts may compose most of the respondents due to ease of researcher's access and their availability. The number of respondents taken from these groups of health practitioners would not affect the results of the

study, as the shift they are assigned was not a criterion in the selection of samples. Besides, these health workers assigned to the morning and afternoon shifts have experienced the evening shift, too. It is because scheduling of shifts is rotational in nature. In addition to the above, no particular nationality and gender were preferred because the study was cross-sectional. Newly hired staff members were not included because as new staff, they cannot give definite responses on items called for in that particular aspect of the study and the newly hired staff member lacks a first performance appraisal. In addition, only those health workers and health managers who signed the Participant's Consent Form (Appendix C) were taken as respondents for ethical reasons.

Furthermore, the language used in all documentations, such as consent forms and survey questionnaires, was English, as it is the common and official language in the hospital and among health workers. The number of respondents included in the study was 60 health workers and 40 health managers working in MOH facility in Jazan region.

### **3.6.2 Data collection**

Instruments for data collection included the survey questionnaire and semi-structured interviews as reflects the mixed method approach (Basavanthappa 2003).

#### **3.6.2.1 The survey questionnaire**

The questionnaire was the primary tool to gather specific information. It is understood that questionnaires or social surveys are methods used to collect standardized data from large numbers of people in a statistical form. Among the types of surveys identified by Ackroyd and Hughes (1981), the factual survey was used to collect descriptive information in order to make generalisations; thus, surveys should be based on carefully selected participants such as health workers and health managers. Use of questionnaires or social survey is the method chosen because it is practical, can collect large amounts of information from large number of people in a short period of time and in a relatively cost effective way. It is easily carried out by the researcher or by any number of people with limited effect to its validity and reliability. According to Sarantakos (2005), results of the questionnaires can be easily analysed, allow for comparison and quantification of the data, and irrelevant responses are avoided because the closed-type questions were used.

The use of questionnaire as discussed above was used (see Appendices I and J). Part I of the questionnaire dealt on profile of the health practitioners. Their profile was used to draw out implications to the delivery of healthcare services in Jazan region. It included items about their age, nationality, gender, highest educational qualification, present designation and number of years as health practitioner. In addition, information derived from there was useful in the analysis by identifying, in general, which level of staff may have experienced further education.

Part II sought information on the health practitioners' views on workplace and incentives and work performance. Specifically, it solicited the respondents' assessment on the utilization of performance appraisal, their views on remuneration, benefits and recognition, assessment on staffing, work schedules, and staff development.

Part III was focused on issues relating to their work performance. To support the information obtained from this, the questionnaire also included qualitative items about their opinions in relation to their needs for maintaining performance, management tasks and management skills.

In this section a five-point Likert's scale was used to measure responses on items about workplace and incentives, while a four-point Likert's scale was used to measure the factors affecting the performance. The difference of scale and arbitrary description of the points were brought about by the nature of the questions being sought. This is a robust thing to do in terms of reliability. As recommended by Dilman et al. (2009), four or five categories should be used in a Likert point scale. This tool was designed after the objectives of the study were identified and was designed to contain items that collect information to answer them.

The questionnaire was prepared by the researcher. The guidelines for designing a good questionnaire, taken from the book of Basavantappa (2003) on Nursing Research were followed. Hence, personal experience and observation by the researcher; along with materials based on the analysis of previous researches and literature reviewed (Al-Hamadi, 2009; Dimabayao, 2002) were the basis for conceptualizing the items that were laid down in the questionnaire.

When the draft of the questionnaire was done, it was subjected to content validation and pilot testing. The content validation was done using a field test by inviting three professionals with expertise in the subject matter, knowledge, and educational background in nursing to undertake the questionnaire. Two of them are in the academe, both of whom are involved in research, not only in teaching, but also in practice. The other was a practising nurse involved in education and training of nurses in a hospital. The involvement of this nurse is important because she has a direct knowledge of the health workers and their performance. Content, correctness, and appropriateness of the questions were reviewed. The organization and presentation of the questions were also noted by these reviewers.

Once the tool was validated, a pilot test was conducted among chosen health workers and health managers in the hospital where the researcher is based and in another health facility in the region. These trial respondents, however, were no longer involved anymore as respondents in the final study. It was stressed by Basavanthappa (2003) and Shuttleworth (2010) that a pilot study is a small scale dress rehearsal that proceeds as if it were the actual study, except for the fact that subjects who participate in the actual study are not used and feasibility studies, which are "small scale version[s], or trial run[s], done in preparation for the major study" (Polit et al., 2001, p. 467). Pilot testing the tool is necessary on the following grounds: (a) developing a research question and research plan; (b) establishing whether the sampling frame and technique are effective; (c) assessing whether the research protocol is realistic and workable; and (d) assessing the proposed data analysis techniques to uncover potential problems (Van Teijlingen and Hundley 2001).

A sample of 5 respondents were included in the pilot test. These pilot test participants completed the questionnaire as would be required of study participants. When the pilot copies were collected and collated, the responses were analysed so that the questionnaire could be adapted and further developed, prior to the study proper (Hundley et al. 2000). Those items found to have received no responses were deleted because they were not relevant to the setting or to the respondents. The validation and pilottesting of the questionnaire contributes to the researcher's confidence to use it during the final administration of the tool to the final or actual respondents of the study, improving the credibility of the research (Basavantahappa, 2003; Sevilla et al., 1995).

### **3.6.3 Semi structured interview**

Semi- structured interviews were used to support the questionnaire (Harris and Brown, 2010) and a total of 60 health workers and 40 health managers were interviewed. This was done to obtain deeper meaning on the data collected from some of the respondents. Interesting and unusual responses were followed up through this technique. Trigger questions asked (see Appendix D) were based on results from the questionnaire and literature. Hence, no detailed structured interview guide was prepared. All responses were properly documented in a logbook so that during the analysis and discussion of the data they were reviewed as they were used to amplify interpretation of data. It is more usual for semi structured interviews to be recorded with a digital recorder. However, in this cultural context any suggestion of this data capture method would be met with suspicion and potential withdrawal from the study, thus only notes were relied upon to record points of from the interview to ensure that personal views were gathered. This meant the study has a small qualitative element, and allows that the study is a mixed method (Brookhart and Durkin, 2003; Lai and Waltman, 2008). Use of qualitative interview data often gather more in-depth insights on participant attitudes, thoughts, and actions (Kendall, 2008) and thus, the qualitative data were used to support the quantitative data and offered some explanations for the results. This was very helpful since information that is not numerical in nature were obtained. The previous literature also suggests that qualitative research is used to go deeper into issues of interest and explore nuances relative to the problem at hand. In qualitative research, data are based on personal interactions, which lead to negotiated and contextually based results (Fontana and Frey 2000; Silverman, 2000, 2006).

## **3.7 Data Analysis**

### **3.7.1 Statistical analysis**

All quantitative results gathered were statistically explored and described through use of the percentage and weighted mean. The percentage was used to quantify the data regarding the profile of the respondents. Items considered in the profile were limited to age, nationality, gender, highest educational qualification, present designation and number of years as health practitioner. The weighted mean was used the treat the data on the assessment of the health practitioners on items on workplace, incentives, and on factors affecting performance.

Because this study data were frequencies and distributions, a weighted average was used to account for the fact that there are multiple instances of each type of data. When working with data that is unequal (for example, averaging averages), a weighted average becomes practical to use (James, 2006). The weighted mean is similar to the ordinary mean, except that particular data points contribute more than others to the mean calculation instead of each data point contributing equally to the final average (James, 2006). Therefore, a weighted average can be used when particular data carry more weight (i.e., are more important than other values) and therefore, the data should contribute more to the final average (James, 2006).

The percentage technique was done either through a calculator and/or Microsoft Excel. The calculation of the weighted mean value was done using internet published statistical calculator, because of its availability to the researcher and in the kingdom.

All quantified data were presented in tabular form to facilitate analysis and interpretation. The presentation and discussion of data was organized following the sequence of the objectives of this study and is presented in chapter 5. This discussion started with the profile of the health workers and health managers. This is just but proper to provide a background about them. They are the focus of the study and that whatever were found as urgent needs to support improvement could be addressed accordingly. The discussion of assessment of the workplace, incentives and factors affecting their work performance came next. Analysis and interpretation of the quantified data was done. Findings as weak points and conditions necessary to overcome were highlighted through the analysis.

Implications of findings were also made. Findings from the two objectives of the study were the basis in realizing the ultimate objective, which is to develop a strategic plan to address the factors affecting work performance so that healthcare facilities in the region will be provided with highly qualified health practitioners to deliver quality healthcare services to the clients. Conclusions were drawn from the findings from which recommendation were made and questions designed as triggers for interview.

### 3.7.2 Qualitative Data Analysis of Interview Data

Qualitative data obtained from interviews were examined within the context of the survey questions using a content analysis technique. Qualitative content analysis was used to identify relevant and/or common responses from the qualitative, open-ended survey questions, which provided in-depth explanations for responses and could be used to indicate commonalities or themes in the data.

Conventional content analysis, often used when the researcher aims to describe a phenomenon, is appropriate when existing theory or research literature on a phenomenon is limited (Hsieh and Shannon, 2005). This design allows the thematic categories to emerge from the data, using inductive category development (Hsieh and Shannon, 2005; Mayring, 2000). The qualitative, content analysis of the data begins with reading all the data word for word to derive codes and to generate the themes and capture key concepts (Hsieh and Shannon, 2005; Miles and Huberman, 1994). The researcher labels the codes reflective of the key thoughts and codes are then sorted into categories of related codes. Emergent categories are organized and grouped to create meaningful clusters (Coffey and Atkinson, 1996; Hsieh and Shannon, 2005; Patton, 2002).

### 3.7.3 Ethical Consideration

The researcher took caution and followed proper procedure in undertaking the study, particularly in the collection of data. Ethical considerations observed by the research included:

a. **Informed consent** - refers to an ethical and doctrine based on the understanding that the participant has been informed about the purpose and nature of the study, and consequently has freely consented to it. The primary focus of consent should be on informing and protecting research subjects, through disclosure and discussion of the relevant information, meaningful efforts to promote participants' understanding, and by ensuring that decisions to participate, or to continue participating, are always made voluntarily (Guraya et al., 2014, Glickman et al., 2009). Thus, in this research, it is essential to inform participants about the purpose of the study and how they will provide the researcher with data through obtaining each participant's signature on the information sheet, which indicates that they understood and conform to the procedure in voluntary participation. However, it must be recognised that as the researcher is a senior health manager, this may affect participant's perception of whether they take part or not. The participant consent form is shown in Appendix C.



b. **Confidentiality** – means the nondisclosure of certain information except to another authorized person. The concept of confidentiality applies that the information a person reveals to a professional is private and has limits on how and when it can be disclosed to a third party. (Mielke 2002). The participants will be made aware that results of the study will be upheld with utmost confidentiality and that writing their names in the information sheet will not be even required or optional. To achieve this all participants will be allocated a numeric identifier on the questionnaire, no names or other details will be asked for. Data will be stored in a secure environment such as a password protected computer, and copies will be held in a locked filing cabinet in a secure office.

c. **Respect and responsibility** - Respect in research refers to respect for people and respect for truth. People have the right to dignity and privacy (informed consent and confidentiality). All possible efforts should be directed to avoid plagiarism and determining false conclusions by over and under emphasizing the results (Tauber, 2005). Responsibility of the human subject involves voluntary informed consent, privacy, and disclosure. The researcher is responsible for maintaining the reputation of educational research by adhering to the highest standards of quality research to the best of his ability.

Ethical approval was gained locally and through the QMU processes for this study (see Appendix E).

### 3.8 Summary

This chapter described the methodology used to meet the goals of the study, which were to explore factors that influence health practitioners' performance. This knowledge would facilitate development of appropriate support and education for health care professions in delivering quality health care. To achieve this, a descriptive cross-sectional study was used. Data reflective of participants' characteristics are age, gender, nationality, educational qualification and work designation were collected using both a survey questionnaire and semi-structured interviews from different health care facilities under the Ministry of Health in Jazan region. The total sample included a total of 100 participants, 60 health workers and 40 health managers who are working in MOH facility in Jazan region. The data were analysed using a combination of quantitative statistical analysis of the survey questions and qualitative content analysis of the interview data. Thus, the chapter provided a detailed discussion on the sample, how the data were collected, and

how the analysis of the data was completed. The next chapter will provide the results of the data analysis.

## **CHAPTER 4: RESULTS**

### **4.0 Introduction**

As the data was gathered using a mixed method approach mainly through survey and with a small semi-structured interview to illuminate the quantifiable data, it is appropriate to present the findings from both concurrently.

#### **4.1 Quantitative and qualitative findings**

The results of the survey were quantified and were treated statistically using descriptive statistical analysis. Results were placed in tabular form to facilitate analysis and discussion. Some results were presented in a comparative table to enable a better and clearer understanding about the conditions of the respondents. This was done especially because there were two groups of respondents used. All quantitative results gathered were statistically treated through use of the percentage and weighted mean. The percentage was used to quantify the data regarding the profile of the respondents. Items considered in the profile were limited to age, nationality, gender, highest educational qualification, present designation and number of years as health practitioner. The weighted mean was used to treat the data on the assessment of the health practitioners on items on workplace, incentives and on factors affecting performance.

The percentage technique was done either through a calculator and Microsoft Excell. The calculation of the weighted mean value was done using internet published statistical calculator which are free particularly the one published by [www.thinkcalculator.com](http://www.thinkcalculator.com) because of its availability to the researcher and in the kingdom.

#### **4.2 Profile of the Respondents**

There were seven characteristics used to describe the respondents. These were age, nationality, gender, highest educational attainment, number of years as health workers and present designation (see Tables 2 – 7).

**Table 2          Age of Health Practitioners**

Age Group (years)	Health Workers		Health Managers	
	Frequency	%	Frequency	%
20 – 29	34	56.67	28	70
30 – 39	15	25.00	8	20
40 – 49	6	10.00	4	10
50 – 59	4	6.67		
60 – over	1	1.66		
Total	60	100.00	40	100
Mean	31.17 years old		28 years old	

Table 2 shows that the ages of the health practitioners range from 20 to more than 60 years old. Both the health workers (34 or 56.67%) and health managers (28 or 70%) are mostly in the youngest age group (20-29 years old). Their oldest age, however, varies. Among the health workers, one or 1.66% was noted to be in the age bracket of 60-over while the health managers' oldest ages were between 40-49 years old where there are 4 or 10% of them. When their mean age was determined, it was found out that the mean age of the health workers was 31.17 years old, while that of the health managers was 28 years old. These average ages are younger than those found by Hodes Research Group in California in 2004, where the male nurses had an average of 44 years old and the largest segment was noted between 45-54 years old (Bernard Hodes Group, 2004). Even in the study by Yamada (2002), it was revealed that the mean ages of the nursing home aides, home care aides, and hospital aides were 36.4; 42.8 and 38 years old, respectively.

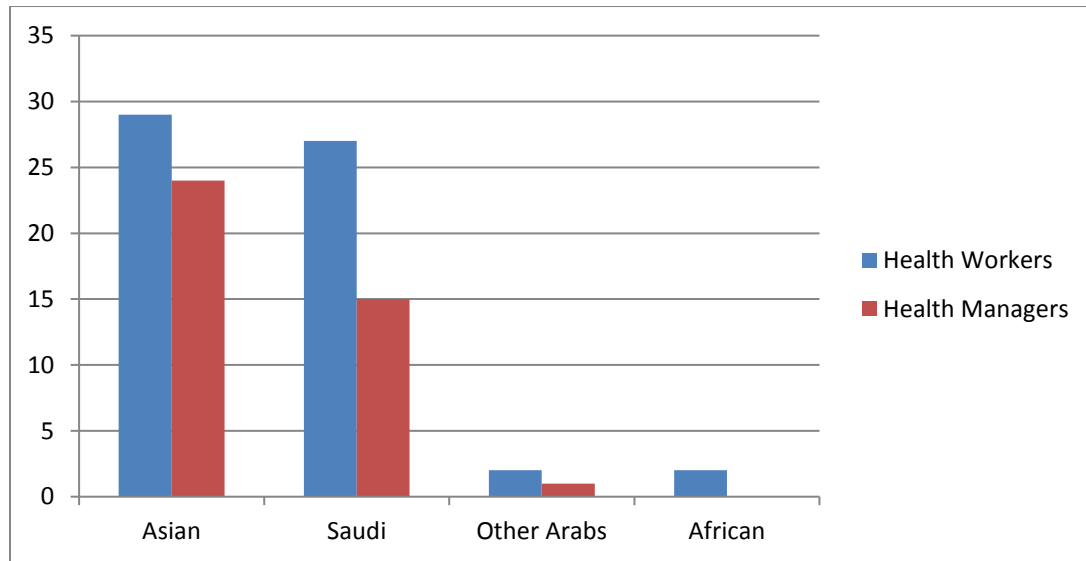
It also was noticed that the health managers were younger compared to the health workers. This could be brought about by the recent developments in Saudi Arabia of encouraging health professionals to pursue professional growth in terms of education. Hence, when they go back to work, they usually are designated as managers. In addition, it can be noticed from the health worker data that as they advanced in age, their number decreases. This is likely a result of turnover of expatriate employees. Such turnover is caused by non-renewal of contract, hence they exit from the kingdom and return to their country of origin. In some instances, an employee leaves his present

job because of a more promising employment in terms of salary. Consequently, they transfer to another employer but still with the same nature of work.

**Table 3 Nationality of Health Practitioners**

Nationality	Health Workers		Health Managers	
	Frequency	%	Frequency	%
Asian	29	48.34	24	60
Saudi	27	45.00	15	38
Other Arabs	2	3.33	1	2
African	2	3.33		
Total	60	100.00	40	100

As it has been pointed out in the literature review, there is a shortage of health workers in Saudi Arabia (Pallot, 2011; Almalki, Fitzgerald and Clark, 2011; Dimabayao, 2002). Hence, in Table 3 it can be seen that they come from other countries. It can be noticed that both groups of respondents are composed mostly of Asians. There are 29 or 48.34% of them are health workers while 24 or 60% are health managers.



**Figure 2. Graph accompanying Table 2**

Saudis compose the next group where their number (27 or 45%) is slightly lower compared to Asians who are in the group of health workers. As to the health managers, 15 or 38% are Saudis.

The reason why many Saudis have a number close to Asians is likely brought about by the effect of the implementation of the Saudization or nationalization policy.

The table also shows that there are those who come from other Arab countries like Egypt and Jordan, Syria and some countries from Africa. However, their number is insignificant compared to their Asian and Saudi counterparts as seen in the graph accompanying the table (Figure 2).

The insignificant number of health care workers coming from neighbouring Arab countries is likely due to currency equivalents in their home countries. A google search with regard to this matter (14 March 2016) showed that 1 SAR (Saudi Arabian Ryal) is equivalent to 2.39 Egyptian pound; 0.19 Jordanian dinar and in Sudan (a country in Africa) is 1.63 Sudanese pound. With this, it is not very encouraging for them to leave their country to work in Saudi Arabia.

Another reason why there are fewer number of health workers and health managers coming from other Arab countries could be due to the fact that the respondents used in this study were charge nurses, head nurse and nurse supervisors. This means that many of them are in this category of health workers. As per observation by the researcher, they are many in the level of staff nurses.

**Table 4 : Gender of Health Practitioners**

Gender	Health Workers		Health Managers	
	Frequency	%	Frequency	%
Male	19	31.67	6	15
Female	41	68.33	34	85
Total	60	100.00	40	100

Table 4, which is about the gender distribution of the respondents, shows that both health workers and health managers are mostly female. This is the same finding in the study by Dimabayao (2002). The female health workers make up 41 or 68.33% while the males are 19 or 31.67%. The health managers comprise 34 or 85% females while there are only 6 or 15% males. It was only in Somalia where most health workers are males (WHO report). This implies that there are few males in the nursing category of allied health specialties in Jazan, Saudi Arabia. In other words, health practitioners in Jazan region are dominated by females.

**Table 5            Highest Educational Qualification**

Educational Qualification	Health Workers		Health Managers	
	Frequency	%	Frequency	%
Diploma in Nursing/ Midwifery	28	46.67	22	55
BS in Nursing/ Midwifery	6	10.00	6	15
Other Bachelor's degree program	13	21.67	10	25
Master's degree	2	3.33	2	5
Doctoral degree (Ph.D.)	0	0	0	0
Medical degree	6	18.33	0	0
Others	0	0	0	0
Total	60	100.00	40	100

Landing in a good paying job and rank require the obtaining of a higher level of education. These are outlined in the Guidelines of Professional Classification and Registration for Health Practitioners by the Saudi Commission for Health Specialties (2014). For example, Article 6-1 of the aforementioned guidelines states that a health practitioner with a Bachelor's degree in nursing from at least a four-year program, plus an internship or one year experience are classified into the rank of nursing specialist. The same guideline states that health practitioners with a diploma certificate lower than a bachelor's degree level in one year of the allied health specialties are classified into the level of technician rank provided that the study period is not less than two years. Those who finished a Master's degree in nursing are classified into the rank of senior nurse specialist. Those who obtain a doctorate, or PhD, degree and are in the classification of senior nurse specialist are allowed to apply for a consultant rank after obtaining experience not less than three years after the date from of graduation in the specialty field.

Table 5 shows the highest educational qualification of the respondents. It can be noticed that most of the respondents in both groups are graduates in the Diploma program in nursing and midwifery. On one hand, there were 28 or 46.47% among the health workers who finished a Diploma in Nursing/Midwifery. On the other hand, there were 22 or 55% from among the health managers who obtained that educational qualification. Those who finished a bachelor's program in nursing and midwifery among the health workers are 6 (or 10%), while the health managers are 6 (or 15%) of the total number of respondents. Among the health workers, it could be seen that there are 6 (or

18.33%) who has a degree in medical courses. There are two in both groups who have a master's degree. No participants in the sample have finished a doctoral degree.

The data imply that the health workers and health managers mostly have educational attainment lower than what is required to their positions based on the Guideline of Professional Classification and Registration for Health Practitioners implemented in 2014., which is because the health workers and health managers used in this study were placed in those designations (see Table 6) before the implementation of the said guideline. It is, therefore, necessary that they should undergo professional growth to be aligned with the provisions and guidelines set by the Saudi Commission on Health Specialties. Their professional growth will also equip them with current knowledge, trends, and skills in the practice of their profession as well as gaining academic knowledge on management and leadership. As such, this will contribute to the delivery of better quality of health care services, which will also result to increase patient satisfaction.

**Table 6a      Present Designation of Health Workers**

Designation	Frequency	Percent
<b>A. Nursing Category:</b>		
Charge Nurse	30	50.00
Head Nurse	7	11.67
Nurse Supervisor	10	16.66
<b>B. Medical Category:</b>		
Resident	3	5.00
Specialist	3	5.00
Consultant	7	11.67
Total	60	100.00

Given the inclusion criteria in this study, health workers in the nursing category included were charge nurses, head nurses, and nurse supervisors; therefore, no staff nurses were involved. Thus, it can be noticed in Table 6a that in the nursing category, most of the health workers are charge nurses (30, or 50.00%). The charge nurses are responsible in the day-to-day affairs of the wards.



Apparently, there are many charge nurses not only because there are many wards in the hospital but it is attributable to the socio-cultural practices in Islamic country like Saudi Arabia; the male wards are totally separate from the female wards.

There were 7 (or 11.67%) head nurses. Their duty is to direct, organize and make strategic plans for the nursing they are assigned. They also assess, evaluate and set nursing standards and objectives of the organization.

The nurse supervisors comprised 10 (or 16.66%) of the health workers. Their primary responsibility is to promote and look into the daily management and planning in the patient care area. They are also responsible in directing and developing staff and collaborate with physicians and other ancillary services and paramedical specialists in the hospital.

In the medical category, most of the participants worked as consultants (7 or 11.67%). There were 3 (or 5.00%) each who are residents and specialists.

**Table 6-b      Present Designation of Health Managers**

Designation	Frequency	Percent
Nurse Manager	8	20.00
Nursing Deputy Director	8	20.00
Unit Manager	24	60.00
Total	40	100.00

Among the health managers, there were 8 (or 20.00%) who were working in the capacity as nurse manager. Their duties are focused on the evaluation of staff nurses, provide feedback and mentor, developing educational programs and maintaining inventory of medicine, equipment and supplies. Another 8 (or 20.00%) are nursing deputy directors. The nursing deputy director sees to it that high quality nursing service is provided by the staff and leads on the governance of nursing standards. In other words, the nursing deputy director is involved in professional leadership to nurses. The table further shows that 24 or 60.00% are unit managers. The responsibility of looking into all aspects of operating units within the health facility rests on his shoulders. In other words, his primary responsibility is on supervising the nursing staff to monitoring patient care.

**Table 7            Number of Years as Health Practitioner**

Number of Years	Health Workers		Health Managers	
	Frequency	%	Frequency	%
1-5	27	45.00	5	12.5
6-10	24	40.00	13	32.5
11-15	5	8.33	9	22.5
16-20	3	5.00	6	15.0
21-above	1	1.67	7	17.5
Total	60	100	40	100
Mean	6.92 years		12.63 years	

As to the number of years the health practitioners have been in the service, Table 7 shows that most of the health workers appear to be new in the health care facility where they are employed. It is because most of them have been in the service between 1-5 years as indicated by 27 or 45%. This was followed those whose work experience is between 6-10 years as signified by 24 or 40%. For those who have been in the service between 11-15 years were 5 or 8.33%. There were 3 or 5% who have been in the service between 16-20 years while there was 1 or 1.67% with 21years and above. In contrast, most of the health managers reported that they have been in the service between 6-10 years (13 or 32.5%). Those who were found young in the service were only 5 or 12.5%. As to those who have been employed between 11-15 years were 9 or 22.5%. Health managers with 16-20 years of work experience were 6 or 15%. There were those who have served for 21-above years. This was signified by 7 or 17.5%.

The average number of years these health practitioners have been in the service shows that it is 6.92 years for the health workers and 12.63 years among the health managers. Apparently, the health managers have longer number of years as health practitioners compared to the health workers. This disparity of figures implies that the health managers have been in the service ahead than the health workers. It must be remembered that the position of a health manager considers length of service as among the criteria in selecting and designating them. In other words, their experience counts in putting the health practitioner to that position.

### 4.3 Assessment of Health Practitioners on Workplace and Incentives

The results of the survey in this section are separate between the health workers and health managers. This is because of the difference in the nature of their jobs, functions and responsibilities. Further, data taken from them was through an interview.

#### 4.3.1 Utilization of performance appraisal

Table 8 (page 75) shows that all the statements regarding performance appraisal and utilization in their organization or unit were all agreeable to the health practitioners. The overall mean is 3.66. The variation of values is caused by the differences in their experience. It is because these health practitioners used in this study come from different health care facilities in Jazan region. It can be noticed from the table that the three leading statements regarding the utilization of performance appraisal, in their descending order of values are (a) objectives to be achieved are known by individuals to be assessed ( $W_m=3.92$ ); (b) self-assessment by employees to review their own performance is done ( $W_m=3.78$ ); and (c) prompt action is taken when performance falls below acceptable standards ( $W_m=3.70$ ).

Because the statement with highest value was on knowledge of objectives to be achieved are known by individuals to be assessed, during the interviews, the researcher used the question from the semi structured interview schedule: *“How were you provided with the objectives to be assessed?”* Responses are identified by the code used to anonymise the respondents: Health worker 1 (HW 1) and health manager 1 (HM1) so on.

In most hospitals, the common responses were,

HW 4: *“sometimes we are called for a meeting after a memorandum is issued;*

HW1: *“sometimes we personally ask for further clarification about the objectives after the notice of having performance appraisal was issued”.*

thus indicating that details of clarification were given officially.

However in some hospitals, the common answer was:

HW 12 *“our fellow health workers inform us”*; which is a much more informal process

A follow-up question in the schedule was *“Why does this happen?”* with a common response being,

HW 12 *"We were not on duty when the conference was called."*

From these responses, it could be deduced that the health workers experience several ways of knowing the objectives of the performance appraisal some which may be less accurate.

The statement showing the lowest value, but still described to be agreeable to the health practitioners was on providing constructive feedback on performance appraisal on a regular basis (Mw=3.48). This was followed by the statement that employees are given the opportunity to comment on the result of their performance (Wm=3.50) and one-to-one performance interview on the outcome of performance appraisal conducted (Wm=3.53).

Providing constructive feedback on performance appraisal on a regular basis appeared to have the lowest weighted mean value, but still within the limits of "agree." In this regard, I asked charge nurses from the interview schedule; *"How did you know that the feedback was constructive?"*

Common responses given were: HW 6 *"It was politely said;"* HW2 *"There was respect;"* HW 8 *"I was not embarrassed."*

This was followed-up by asking, *"Can you give me an example of a feedback they gave you?"*

One response was

HW 14 *"I was asked to comment why I rated myself 'exceeds expectations' on knowledge of work and I said 'I learned it during my training.'" So the manager said, 'Alright, I will respect that, so maintain it and if you could even do better in the coming days, it will be appreciated.'"*

This question asked above was triggered by the fact that most of the health workers finished Diploma in Nursing (see Table 5) and being a charge nurse, she is in-charge with the daily affairs in the ward.

It can also be noted from the table that two statements regarding the utilisation of performance appraisal received similar values. These were "performance standards expected from staff are clear and understood" and "managers/supervisors inspire the staff to do their best." Both of these statements had a weighted mean value of 3.68. Their rank is 5.5 based from the nine statements for this aspect.

**Table 8            Assessment of Health Workers Regarding Performance Appraisal and Utilization in their Organization or Unit**

No.	Statements	Wm	Rank	Int.
1	Objectives to be achieved are known by individuals to be assessed.	3.92	9	A
2	One-to-one performance interview on the outcome of performance appraisal is conducted.	3.53	3	A
3	Performance standards expected from staff are clear and understood.	3.68	5.5	A
4	Constructive feedback on performance appraisal results is provided in a regular basis.	3.48	1	A
5	Feedback on how the employee is performing is provided throughout the year.	3.67	4	A
6	Prompt action is taken when performance falls below acceptable standards.	3.70	7	A
7	Managers/supervisors inspire the staff to do their best.	3.68	5.5	A
8	Employees are given the opportunity to comment on the results of their performance.	3.50	2	A
9	Self-assessment by employees to review their own performance is done.	3.78	8	A
Overall Mean		3.66	Agree	

Legend: 1.00 - 1.80 = Strongly Disagree (SD)

1.81 - 2.60 = Disagree (D)

2.61 - 3.40 = Uncertain (U)

3.41 - 4.20 = Agree (A)

4.21 - 5.00 = Strongly Agree (SA)

Among the responsibilities of a nurse manager and supervisor is evaluating the performance of staff nurses. The researcher asked, *“Why do you think inspiring the staff to do their best did not come out as rank 1?”*

The most common response was: HM 3 *“It’s because we do not do it everyday; it is often done when a staff is not yet very much familiar with the Arabic language to communicate with the patient.”* Inspiring the staff do their best in this kind of situation helps them to gain confidence, especially given that most of them are expatriates from other Asian countries (see Table 2), who are not Arabic-speaking.

On the part of health managers, results of the interview conducted with the health managers showed that their responses on their assessment on the utilization of performance appraisal were limited to HM 2 *“having a concrete feedback about their performance,”* HM 4 *“used as basis in re-assessing their knowledge and skills,”* and HM 10 *“basis for requesting for professional growth.”* It was noticed that these statements were repeated by other health workers. Hence, they are regarded as common to them. However, there were instances when the health manager could not give a definite response, so the interviewer gave some triggers to guide them on a response. This did not mean, however, that the interviewing is “putting the words into their mouth”. It was made to clarify the item to them so that the desired response is taken. The researcher asked *“Who rates you in your performance?”* There was one answer for this which is the HM 6 *“Human Resources Manager but they give us the privilege of evaluating ourselves.”* a prompt question was then *“Why do you need to have a concrete feedback about your performance if you are rating yourself?”* This was asked next and the common response taken was HM 8 *“Our rating was not final; the Human Resource Manager makes a review before it is made final.”* With this response, it is actually important for them to have a concrete feedback about their performance. This justifies the other two utilization of performance appraisal as cited above, which include (a) basis in re-assessing their knowledge and skills, and (b) basis for requesting for professional growth.

#### **4.3.2 Remuneration, benefits, and recognition**

As to the assessment of the health workers regarding their remuneration, benefits and recognition which are shown in Table 9, it turned out that generally, they were uncertain as evidenced by the overall mean of 3.30. Again, it can be said that this is brought by differences of experiences in the workplace. However, there were three statements which they were agreeable. These were: a) remuneration is competitive compared to other organizations (Wm=3.53); b) remuneration is in accordance with experience (Wm=3.57); and c) remuneration is in accordance with job responsibility (Wm=3.60).

There are times when an employee asks about remuneration and benefits when they are being recruited especially when these are not brought out by the employer or agency. But this has been resolved by indicating it in the job offer during the recruitment process. However, when they are

already in the kingdom and have been in the service for one year, this is the time when the need to know about increase in their remuneration begins. Health workers who have been working in the kingdom for longer periods do not ask the question anymore. While it is true that their salaries are increasing, yet the percentage of increase is what they want to know.

*“Why are you interested to know the percentage increase of your salary?”* was the question of the researcher to the respondents. The common response was HW 5 *“It is the way they are expressed in my country”*. As it has been presented in previous data, most of the health workers come from Asian countries (see Table 3) and most of them are young in the service (see Table 7). It was learned from them that the practice of giving notices of salary increases in their country is in terms of percent. Hence, it is just but expected that they ask if it is the same way in the kingdom. The practice in Saudi Arabia in giving salary increases in hospital operating under the MOH is also in percent but it is limited to 5% annually until they reach the limit.

Matters where the health workers are uncertain regarding their remuneration, benefits and recognition in their ascending order were on: a) fringe benefits are known to workers ( $W_m=2.87$ ); b) hardworking employees are recognized ( $W_m=3.07$ ); c) health workers are satisfied with their fringe benefits ( $W_m=3.12$ ) and d) opportunities exist for career advancement ( $W_m=3.32$ ). Though these are discussed to them during their admission to the work, changes that take place or made when there is a change of status of the health worker, like bringing their family to the kingdom, fringe benefits are no longer familiar to them. This is the point that makes them uncertain about the statements concerning remuneration, benefits and recognition.

The statement with lowest value was found on fringe benefits where they were uncertain. This motivated the researcher to ask *“What fringe benefits are given to you as employee under the Ministry of Health?”* Common responses given by expatriates staying in an accommodation were HW 15 *“free accommodation, food allowance, round trip ticket, medical services and sick leaves”*. Married expatriates who have their family in the kingdom were also asked the same question. It was found out that it was the same except that tickets issued to them when they go for a vacation to their country is only for the health worker; it is not a benefit extended to their family members. They are also given monthly transportation allowance. The researcher asked *“Do you talk about*

*differences of fringe benefits you receive with your colleagues who stay in the accommodation?"* The response given was HW 3,8,15 "No". "Why?" I continued. HW 8 "It is not a nice topic to talk about in the workplace" was the common answer.

The researcher also asked a question similar to the way it was stated in the questionnaire as "Are you satisfied with your fringe benefits?" This was asked to both groups of health workers (those who stay in the accommodation and those who do not). More responses given were "Yes"; some said "*I think so*" while others said "*just right*". These responses validated the level of their response as "Uncertain" as shown in Table 9.

From the information above, it appears that health workers staying in an accommodation is not very familiar with fringe benefits of those who stay in apartments or flats. Further, there were more statements presented in the table which received "Uncertain" level of response compared with those statements where the health workers showed to agree.

It can be noticed from the data, too, that statements where the health workers were agreeable pertain to remuneration or salaries. This implies that this is clear and definite to them. Items which were uncertain to them pertain to fringe benefits, career advancement and recognition. There is a need, therefore, to address this situation. It's importance is supported by the Two-Factor Theory by Herzberg (1987) stressing that recognition, growth and promotional opportunities are motivational factors contributing to improve performance because of the satisfaction they give to the employee.



**Table 9 Assessment of Health Workers Regarding their Remuneration, Benefits and Recognition**

No.	Statements	Wm	Rank	Int.
1	Remuneration is competitive compared to other organizations.	3.53	5	A
2	Remuneration is in accordance with experience.	3.57	6	A
3	Remuneration is in accordance with job responsibility.	3.60	7	A
4	Fringe benefits are known to workers.	2.87	1	U
5	Health workers are satisfied with their fringe benefits.	3.12	3	U
6	Opportunities exist for career advancement.	3.32	4	U
7	Hardworking employees are recognized.	3.07	2	U
Overall Mean		3.30	Uncertain	

Legend: 1.00 - 1.80 = Strongly Disagree (SD)

1.81 - 2.60 = Disagree (D)

2.61 - 3.40 = Uncertain (U)

3.41 - 4.20 = Agree (A)

4.21 - 5.00 = Strongly Agree (SA)

On the part of the health managers, their assessment on remuneration and benefits showed that it is in accordance with qualification and designation. They also said that they are aware and informed about their remuneration and benefits. Further, they believed that benefits and remuneration, to some extent, motivates them to grow in the profession. It is because a higher educational attainment means additional remuneration and/or promotion if a position is available. However, they were uncertain whether or not they have the same remuneration and benefits with their peers in other health facilities.

#### **4.3.3 Staffing and work schedules**

As to the health workers' assessment regarding staffing and work schedules, Table 9 shows that out of the nine statements to assess this component, most or 5 had “uncertain” interpretation of the weighted mean values obtained on those statements. As a whole, this component received an overall mean value of 3.01.

Statements where the health workers were uncertain were on: a) opportunities exist for a flexible work schedule (Wm=3.30); b) care and support of employees in the form of counselling at the

workplace is available ( $W_m=2.93$ ); c) the overall work schedule is fair ( $W_m=3.08$ ); d) getting opportunities to make inputs into staffing policies and procedures ( $W_m=3.28$ ) and e) there is a good balance between people who supervise work and people who do the work ( $W_m=2.88$ ).

These finding implies that these conditions are not very much visible to them. In other words, they do not often experience them in the workplace. When the researcher asked samples regarding what they experience regarding these situations in the hospital common response was HW 2,7, 5, 15 “*I agree*”. “*What makes you agree with these?*” I further asked.

HW7 “*I am confident that the manager knows what she is doing*” was the response. To those who gave a “disagree” response, the researcher asked them also what make them disagree. The common response was HW 6 “*changes in shifts schedule bringa different experience*”. “*Why?*” I further asked. HW 6 “*Everytime there is a change of shift, the staff nurses who we deal with are also different*”. With these differences in responses, when they were summarized, it resulted to “uncertain”.

The table also showed that the health workers had disagreement on the statements concerning acceptability of overtime ( $W_m=2.23$ ) and allocation of staffs to sufficiently cover current workload ( $W_m=2.17$ ) which was the statement with lowest weighted mean value. This was the basis of the researcher to ask charge nurses available for interview. I asked them “What is the common number of patients attended by a staff nurse during their shifts?” The charge nurse in the medical-surgical ward said, HW 6 “*6 to 8 patients, sometimes 10*” and this is in a tertiary hospital. The same question was asked in a smaller hospital (a general hospital) and the charge nurse said HW 12 “*5 to 6 patients*”. In the paediatric ward, it was learned that 1 room of 6 beds has 1 nurse.

Both statements where the health workers disagreed are the consequence of shortage of staff. It is also brought about by the large number of clients coming to the hospital or health care facility. As a matter policy in Saudi Arabia, medical and health services in government health care facilities are free to legal residents. By legal residents, it means that they are locals with a national ID and foreigners and their family members with residence permits.

Though the health workers were uncertain and disagreed on some of the statements, two statements, however, were noticed to be agreeable to them. These were on the sufficiency of materials and supply (Wm=3.50) and availability of necessary policies (Wm=3.68). Sufficiency of materials and supply in government health care facilities is very laudable. This is to be ready in every case attended, be it on routine or emergency and meets the requirement of the MOH regulations.

Among the health managers, their assessment on this regard was seen on a different magnitude and perspective. It is because they are directly involved in staffing and making of work schedules. All of them considered “overload” as an indication affecting work performance and quality of healthcare. This is followed by the presence of staffs who have just but one year of service in the healthcare facility and is new in Saudi Arabia. Because of this, they believed that requesting a peer to assist and guide the new staff is an additional burden. At times, a staff member is pulled out from another unit because additional workforce is needed in another unit.

**Table 10      Assessment of Health Workers Regarding Staffing And Work Schedules**

No.	Statements	Wm	Rank	Int.
1	Getting opportunities to make inputs into staffing policies and procedures.	3.28	6	U
2	Opportunities exist for a flexible work schedule.	3.30	7	U
3	The overall work schedule is fair.	3.08	5	U
4	Overtime work is acceptable.	2.23	2	D
5	There is a good balance between people who supervise work and people who do the work.	2.88	3	U
6	The allocated staffs in health workers’ unit are sufficient to cover the current workload.	2.17	1	D
7	Care and support of employees in the form of counselling at the workplace is available.	2.93	4	U
8	Materials and supplies are sufficient.	3.50	8	A
9	Necessary policies are available.	3.68	9	A
	Overall Mean	3.01	Uncertain	

Legend: 1.00 - 1.80 = Strongly Disagree (SD); 1.81-2.60=Disagree (D); 2.61-3.40=Uncertain; 3.41-4.20=Agree (A); 4.21-5.00=Strongly Agree (SA).

#### 4.3.4 Staff development

Assessment of health workers on staff development is reflected in Table 11. Generally, the health workers were uncertain on the statements presented therein as shown by the overall weighted mean value of 3.31. The statement with highest value where the health workers are being uncertain is on the availability of good opportunities for continuing education on health care (Wm=3.38). This was followed by “job specific refresher courses are available (WM=3.30) and “in-service training adequately addresses the skill gaps” (Wm=3.27).

The three items where the health workers were uncertain are all about professional growth. Hence, the researcher asked, “*Do you have in-service training programs*”? The common response is HW 4, 2 “*Yes, but not very often*”.

“*Do you attend to these training programs*”? was my next question. The common answer is HW 6, 4 “*Yes, when we are not on duty*” and HW 12, 15 “*Yes, when the training program is intended for us*”. This was verified from the nurse managers and unit manager. The answer was affirmative, that only those who are concerned with the training are advised to attend. This justifies now the response of charge nurses that in-service training program is not very often because eventhough such activities are regularly conducted, not all of them are involved.

Other items where the health workers were uncertain were on 1) an opportunity for advancement in the organization exits (Wm=3.17); 2) availability of good leadership/management training (Wm=3.20), and 3) identifying incompetent health workers and providing them with necessary support (Wm=3.20).

Of the eight statements, there were two items though which the health workers were agreeable about. These were on the participation of health workers in identifying their staff development needs (Wm=3.43) and the necessary training is given to ensure job effectiveness (Wm=3.50). These are very commendable practices in the workplace for these are some ways to promote the morale of the health workers. It could be noted in earlier presentation above that health workers attend in-service trainings only where they are involved. This now collaborates the finding that necessary training is given to ensure job effectiveness in which these health workers agreed.

**Table 11      Assessment of Health Workers on Staff Development**

No.	Statements	Wm	Rank	Int.
1	An opportunity for advancement in the organization exists.	3.17	1	U
2	Good opportunities for continuing education on health care are available.	3.38	6	U
3	The necessary training is given to ensure job effectiveness.	3.50	8	A
4	Job specific refresher courses are available.	3.30	5	U
5	In-service training adequately addresses the skill gaps.	3.27	4	U
6	Incompetent health workers are identified and provided with necessary support.	3.20	2.5	U
7	Good leadership/management training is available.	3.20	2.5	U
8	Health workers participate in identifying their staff development needs.	3.43	7	A
Overall Mean		3.31	Uncertain	

Legend: 1.00 - 1.80 = Strongly Disagree (SD)

1.81 - 2.60 = Disagree (D)

2.61 - 3.40 = Uncertain (U)

3.41 - 4.20 = Agree (A)

4.21 - 5.00 = Strongly Agree (SA)

Among the health managers, they said that staff development is provided but they are not sure whether or not an evaluation of the training provided is done. One health manager said that sometimes an evaluation is done. “*What do you do with the result of the evaluation?*” I asked. The answer was HM7 “*part of documentation*”. Such evaluation is necessary to determine the effectiveness of the training conducted. Kirkpatrick and Kirkpatrick (2006) gave three reasons for evaluation of training and these are 1) to justify the existence and budget of the training department by showing how it contributes to the organization’s objectives and goals; 2) to decide whether to continue or discontinue training programs; and 3) to gain information on how to improve future training programs. To the United Nations Environment Program, it pointed out that evaluation of training not only provide the trainer with useful information in order to further improve the training course but also creates an impression of completeness (UN Environment, 2017). In the case of health care training programs, there should be follow-up made to find out the effectiveness of the training provided through their application in the work setting.

During the interview with health managers, it was found out that they suggest the topics or fields to be given in the training to be carried out. This is practiced because they can see and observe the problems and needs to be provided to the health workers. However, they think that there should be more to be done like workshop and demonstration and return demonstration as part of the training given. If this is done, it is a guarantee that when the health workers return to their assignments, they are ready to implement the changes and developments they learned in the training. Thus, better and improved delivery of health care services is provided to the clients or patients.

#### **4.3.5 Factors Affecting Performance of Health Workers**

Since the health practitioners used in this study are mostly expatriates and young in the service, it is just but expected that there are factors affecting their performance which they encounter. Problems could be viewed to be very broad. This is the reason why the investigator made it more specific to be factors affecting the performance of health workers.

In Table 12, it shows that the factors affecting the performance of health workers in the organization are generally intermediate in nature as supported by the overall mean value of 2.39. By intermediate, it suggests that they are neither major factors nor minor but mid range factors. Of the seventeen (17) problems listed in the table, eleven were found to be intermediate factors while six (6) were major factors. Even patients' satisfaction and feedback which is the primary and ultimate result of performance ( $W_m=1.85$ ) was noted as intermediate factor. Although, this item was found to have the lowest weighted mean value, it could be gleaned that the health workers are doing their best but it could not meet the level of performance desired to the point of satisfaction. Samples interviewed regarding this matter responded HW 9 *"We can only do as much"*. *"Why?"* I asked further. HW 9 *"It is because we believe that the number of staff is not sufficient to the number of patients"* was the common response. *"But we can see them doing their best,"* they continued.

The six items found as major factors when the responses of the health workers were subjected to weighted mean calculation, in their descending order are: a) shortage of staff ( $W_m=3.27$ ); b)

inefficient staff (Wm=2.75); c) inefficient leaders (Wm=2.67); d) benefits like sick leaves and others (Wm=2.62) ; e) staffing system (Wm=2.60) and f) undefined policies and procedures of the organization ((Wm=2.58). Shortage of staff still remains as the number one problem of the health workers. This has been noted as a problem in the past decade as noted in the review of related literature (Dimabayao, 2002; Almalkhi, Fitzgerald and Clark, 2011). This means that the kingdom has not yet come to a point of overcoming the problem, even though recruitment of foreign health workers is made (Pallot, 2011).

**Table 12 Factors Affecting Performance of Health Workers in the Organization**

No.	Problems	Wm	Rank	Interpretation
1	Shortage of staff	3.27	17	Major
2	Language barriers	2.03	5	Intermediate
3	Coordination with other health personnel	1.92	2	Intermediate
4	Patients' satisfaction and feedback	1.85	1	Intermediate
5	Adequacy of supply and resources	2.02	4	Intermediate
6	Staffing system	2.60	13	Major
7	Inefficient staff	2.75	16	Major
8	Job commitment	2.45	10	Intermediate
9	Cultural differences	2.00	3	Intermediate
10	Proper communication skills	2.27	6	Intermediate
11	Managers' leadership style	2.50	11	Intermediate
12	Teamwork	2.28	7	Intermediate
13	Appraisal of personnel	2.38	8.5	Intermediate
14	Remuneration	2.38	8.5	Intermediate
15	Benefits (sick leave and others)	2.62	14	Major
16	Inefficient leaders	2.67	15	Major
17	Undefined policies and procedures of the organization	2.58	12	Major
	Overall Mean	2.39		Intermediate

Legend: 1.00 – 1.75 = Not a factor  
1.76 – 2.50 = Intermediate factor  
2.51 – 3.25 = Major factor  
3.26 – 4.00 = Extremely major factor

Obviously, the presence of inefficient leaders would result to inefficient staff, too. So, the investigator asked “*Why do you feel inefficient in your role as a leader?*” This was asked to both

groups of respondents, the health workers and health managers. Responses worthy to note were: HM 1 *"Our knowledge in leadership is limited,"* HM 6 *"Training on leadership is limited,"* HM 2 *"I am new in my role as a leader."* With these responses, apparently, training on leadership skills and management is necessary.

As it could be noticed from the data, intermediate factors turned out to be the most number of factors affecting the performance of the health workers. The five leading factors in their ascending order are: a) patients' satisfaction and feedback (Wm=1.85); b) coordination with other health personnel (Wm=1.92) and c) cultural differences (Wm=2.00); d) adequacy of supply and resources (Wm=2.02) and e) language barriers (Wm=2.03). There seemed to be a contradictory result found on adequacy of supply and resources in this table and that one in Table 10. In Table 12, it is an intermediate factor while in Table 9 the health workers agreed that materials and supply are sufficient. When this issue was clarified from the respondents through a semi structured interview, it was learned that materials and supplies are really sufficient. However, the use of some materials is too heavy that they are finished fast specially cotton and disposable ones like sterile gloves, disposable syringe, gauze and betadine. Hence, it came out as intermediate factor. So, I asked, *"What cases make heavy use of supplies?"* The response was a reality for they said, HW 12, 15 *"Road traffic accidents", and "surgery"*.

As to the factors affecting the work performance of health managers, it was noticed from the interviews with them that there were some similarities with those ones encountered by the health workers. First and foremost is about the shortage of staff. This was followed by the presence of inefficient staff, staff attitude, qualification of staff, inefficient manager and use of supplies and resources. Their foremost factor is similar with what the health workers have revealed (shortage of staff). It is a factor considered by the health managers in the sense that they could not come up with a very ideal staffing and work schedules when there is shortage of staff. *"How do you overcome this situation?"* was my question. HM 8 *"Sometimes, we request some staff to forego with their day-off or pending-off."* *"Are they given overtime pay for this?"*, was my follow-up question. The answer was *"No; the MOH does not give overtime pay."* This response justifies the finding shown in Table 10 that health workers disagreed on the statement that overtime work is



acceptable. As a consequence, they perceived that the inefficiency and attitude of staff is caused by stress in carrying out their functions in the wards and other units in the health care facilities.

#### **4.3.6 Major Needs of Health Workers**

Table 13 shows the responses of the health workers on their major needs to improve and maintain excellent performance. Obviously, none was found to be major needs. The results show that all the statements presented therein turned out to be moderately needed as indicated by the overall weighted mean values. Primary among these needs could be noticed on using pragmatic approach (fair management) (Mw=2.43). This was followed by the need to be endowed with intellect and strong political will in governance (Wm=2.35). To be able to manage change or able to respond to change pressure of the organization was third in the list (Wm=2.33).

Asked why the health workers need to use pragmatic management, many of their responses were HM 5 *“So that we can make actions immediately with least consultation from higher leaders”* and *“So that we can make decisions according to our observations”*. This now confirms the finding that inefficient staff and inefficient leaders (see Table 12) are major factors affecting their performance. Decision-making is silent in the roles or job functions of health workers. Therefore, if providing them training on leadership skills and management, they would be able to manage their areas better and that is what they mean about fair management. Consequently, they would be able to provide quality service and better work performance.

Three statements with lowest weighted mean values, yet showing that they are moderately needed are on “non-imposition of cultural practices” (Wm=1.93); “fully aware of structure and policies of the organization” (Wm=2.10) and “English proficiency training” (Wm=2.32).

Among the health managers, they were asked about their suggestions to improve the performance of health workers. Most of them suggested *“Weekly program or training and workshop are seen as an immediate solution to problems they encounter”*. Among the trainings they feel very important is on leadership training. They also believe that monthly examination about procedures in their work is necessary. They also voiced out that job descriptions should be revisited in order to have a defined role and such be used as indicators in performance evaluation. Others which

were given by the health managers to improve performance are giving recognition, motivation like upgrading of salaries and benefits of employees.

**Table 13 Opinions of Health Workers on the Major Needs to Improve and Maintain Excellent Performance**

No.	Statement	Wm	Rank	Interpretation
1	Manager's innovative leadership	2.28	8	Moderately needed
2	More advanced leadership training	2.32	9	Moderately needed
3	English proficiency training	2.12	3	Moderately needed
4	Non-imposition of cultural practice	1.93	1	Moderately needed
5	Using proper appraisal system	2.23	5.5	Moderately needed
6	Sensitive to the needs of the general membership	2.23	5.5	Moderately needed
7	Empowerment of its officer and staff	2.27	7	Moderately Needed
8	Pragmatic approach (fair management)	2.43	12	Moderately Needed
9	Fully aware of structure and policies of the organization	2.10	2	Moderately Needed
10	Devoid of self interest	2.22	4	Moderately needed
11	Endowed with intellect and strong political will in governance	2.35	11	Moderately Needed
12	Able to manage change (able to respond to change pressure of the organization)	2.33	10	Moderately Needed
Overall Mean		2.23		Moderately Needed

Legend: 1.00 – 1.75 = Not Needed  
1.76 – 2.50 = Moderately Needed  
2.51 – 3.25 = Much Needed  
3.26– 4. 00 = Very Much Needed

#### 4.3.7 Management Tasks

**Table 14 Involvement of Health Managers on Management Tasks**

No.	Tasks	Wm	Rank	Interpretation
1	Managing conflict	2.40	2	Sometimes
2	Operational conflict	2.33	1	Sometimes
3	Counselling of employees	2.88	3	Often
4	Orientation of new staff	3.38	7	Always
5	Providing continuing to education to employees	3.28	6	Always
6	One-to-one performance interview related to performance outcome	2.78	4	Often
7	Placement of staff according to skills	3.15	5	Often
	Overall Mean	2.89		Often

Legend: 1.00 – 1.75 = Never

1.76 – 2.50 = Sometimes

2.51 – 3.25 = Often

3.26 – 4.00 = Always

In Table 14, it can be seen that the health managers are involved in different management tasks in varying frequencies. Appearing to be a task “Always” done by them are providing continuing education to employees (Wm=3.28) and orientation of new staff (Wm=3.38). Managerial tasks observed by the health workers as “Often” done are counselling of employees (Wm=2.88); one-to-one performance interview related to performance outcome (Wm=2.78) and placement of staff according to skills (Wm=3.15). Managing conflict (Wm=2.40) and operational conflict (Wm=2.33) are tasks which were found out to be “Sometimes” done by health managers.

The degree to which the health managers perform management tasks could be attributable to the training they have attended relative to this matter. Hence, the health managers were asked if they have received any management training in specific aspect related to management. Of the 40 health managers, 8 or 20% responded affirmatively while 32 or 80% answered negatively. Of the 8 health managers who have attended management training, 3 were international in nature while 5 were at the local level. Further, 5 of them considered the training as sufficient to some degree; 1 considered it sufficient to a large degree while 2 said it was only to a sufficient degree. With this finding, it

can be deduced that the health managers need further trainings, to, to make them more effective in their job.

#### 4.3.8 Management Skills

The roles of health managers are different from health workers. This was mentioned relative to the data presented in Table 6. At this point, the self-assessment of health managers on their management skills were sought and results are shown in Table 15. Obviously, all the knowledge/skills presented to them were generally good as evidenced by the overall mean of 3.77. They assessed themselves to be highest in motivation skills ( $W_m=4.05$ ) followed by their problem solving skills ( $W_m=3.85$ ). The health managers were also found to have good skill in organizing facilities, equipment and supplies ( $W_m=3.83$ ). Interpersonal relations ( $W_m=3.78$ ) was also found good as this is important to health managers like them because they are working with people. Having equal rank with this is their assessment on supportive management ( $W_m=3.78$ ) which was also “Good.”

**Table 15 Self-Assessment of Health Managers on their Management Skills**

No.	Knowledge /Skills	Mw	Rank	Interpretation
1	Health service policy implementation	3.70	3.5	Good
2	Planning of health service delivery	3.65	2	Good
3	Development of performance standards	3.73	5	Good
4	Development of skills competencies	3.70	3.5	Good
5	Skills development.	3.80	9	Good
6	Interpersonal relations	3.78	7.5	Good
7	Counselling skills	3.75	6	Good
8	Performance appraisal of subordinates	3.63	1	Good
9	Supportive management	3.78	7.5	Good
10	Problem solving skills	3.85	11	Good
11	Motivation skills	4.05	12	Good
12	Organizing facilities, equipment and supplies.	3.83	10	Good
	Overall Mean	3.77		Good
Legend:	1.00 - 1.80 = Very Poor			
	1.81 - 2.60 = Poor			
	2.61 - 3.40 = Average			
	3.41 - 4.20 = Good			

4.21 - 5.00 = Excellent

The knowledge/skill noted to be low in ranks, in their descending order are: 1) Health service policy implementation and development of skills competencies ( $W_m=3.70$ ); 2) planning of health service delivery ( $W_m=3.65$ ) and 3) their lowest was on performance appraisal of their subordinates ( $M_w=3.63$ ) although it was still found as “Good”.

Although all of the indicators used in the assessment were good, yet much are still needed to be done for a better work performance output as well as better delivery of health care services in the area. It is, therefore, seen to be necessary that there a strategic plan to provide trainings to staffs, the health workers, and the health managers themselves are necessary. In this way, all will benefit from advancing in knowledge and skills through continuing education.

#### **4.4 Influence of the Researcher**

Although as a cross-sectional study, the research was susceptible to bias due to potential for low response and misclassification due to recall bias (Hennekens and Buring, 1987), additional bias was possible through researcher influence, particularly in terms of obtaining the qualitative data during interview data collection. It was noted that there were instances when the participant could not give a definite response during the interview, so the interviewer gave some clues to guide them on a response that is desired. The interviewer intentionally avoided offering the participant a response, but rather clarified the item to the participant so that an appropriate understanding and response could be recorded. The researcher considered and journaled any related preconceived notions or beliefs prior to conducting interviews with participants in an attempt to be aware of and avoid potential biases during the interview and qualitative analysis process (Parahoo 2014).

#### **4.5 Summary**

This chapter has provided details of the data analysis and results of the study. The data analysis supported a mean age of health workers of 31.17 years and that of the health managers of 28 years. The nurses in the study tended to come from other countries, particularly Asian, with Saudis composing the next highest group. Both health workers and health managers were mostly female

and most in both groups were graduates in the Diploma program in nursing and midwifery. The majority of respondents in both groups were Diploma graduates and were relatively new in the health care facility where they are employed (i.e., between 1-5 years, 45%), with an average number of years of service at 6.92 years for the health workers and 12.63 years among the health managers.

Survey scores fell within the agreeable range for all the statements regarding performance appraisal and utilization in their organization or unit to the health practitioners. Statements reflecting the lowest value (but still within the range of agreeable to the health practitioners) included providing constructive feedback on performance appraisal on a regular basis, followed by employees being given the opportunity to comment on the result of their performance and one-to-one performance interview on the outcome of performance appraisal conducted. Although within the agreeable range, the statement that related to providing constructive feedback on performance appraisal on a regular basis appeared to have the lowest weighted mean value. Thus, it was concluded that participants felt it important to have concrete feedback with regard to their performance.

With regard to remuneration, benefits, and recognition, health workers demonstrated a general uncertainty, which was felt to possibly be due to experiential differences in the workplace. It is noted that the participants agreed that remuneration is competitive, and in accordance with experience and job responsibility.

Healthcare workers demonstrated an attitude of uncertainty with regard to staffing and work schedules, while assessment of health workers on staff development generally revealed the health workers were uncertain on the statements presented therein. The statements with highest value included the availability of good opportunities for continuing education on health care, followed by availability of job specific refresher courses and in-service training to adequately fill skill gaps.

The factors affecting the performance of health workers in the organization are generally intermediate in nature. In all, 11 of the 17 problems listed were found to be intermediate factors, while six were major factors. Even patients' satisfaction and feedback, which is the primary and

ultimate result of performance, was noted as an intermediate factor. The six items found as major factors in descending order included shortage of staff, inefficient staff, inefficient leaders, benefits like sick leaves and others, staffing system, and undefined policies and procedures of the organization. Shortage of staff still remains as the number one problem of the health workers in this study. In terms of the perceptions of major needs to improve and maintain excellent performance, none were found to be major needs. Results showed that all the statements presented therein turned out to be moderately needed as indicated by the overall weighted mean values. Primary among these needs could be noticed on using pragmatic approach (fair management), followed by the need to be endowed with intellect and strong political will in governance, and to be able to manage change or able to respond to change pressure of the organization.

Health managers are involved in different management tasks in varying frequencies. Health managers were thought to contribute directly (i.e., a task always done by them), providing continuing education to employees and orientation of new staff. Observed managerial tasks (observed by the health workers as “Often” done) included counselling of employees; one-to-one performance interview related to performance outcome, and placement of staff according to skills. Managing conflict and operational conflict are tasks which were found out to be “Sometimes” done by health managers.

The roles of health managers were found to be different from health workers. The self-assessment of health managers on their management skills were sought and results showed that all the knowledge/skills presented to them were generally good and they assessed themselves to be highest in motivation skills, followed by their problem solving skills. The health managers were also found to have good skill in organizing facilities, equipment and supplies. Finally, interpersonal relations was also found good as this is important to health managers like them because they are working with people. Having equal rank with this is their assessment on supportive management, which was also “Good”.

Despite all of the indicators used in the assessment being good, there is much work to be done before enhanced work performance can be achieved, which will be discussed with the results of this study in the next chapter. It is, therefore, seen to be necessary that there a strategic plan to

provide trainings to staffs, the health workers, and the health managers themselves are necessary. In this way, all will benefit from advancing in knowledge and skills through continuing education.



## **CHAPTER 5: DISCUSSION OF THE FINDINGS**

### **5.0 Introduction**

This chapter discusses the major findings from the study. This is achieved by providing more meaning and deeper analysis and interpretation of the data gathered. The analysis and interpretation of findings were supported by information revealed by previous investigations. Others were taken from the literature review. This was done to affirm the statements given about the data presented.

### **5.1 Influence of the literature**

The review of related literature and studies provided support for the planned data collection in the present work. The work reviewed can be grouped into those that discussed the profile of health care practitioners, the problems they encounter; the factors affecting performance, and the strategic plans to improve performance. It should be noticed, too, that in these studies, several differing names were used, such as health care providers and home care providers. Both of these refer to nurses, midwives, and doctors. In this current study, the term health practitioners is used because it is an inclusive term for health care providers in any setting.

With the aim of providing hospital management a strategic plan for improving the well-being of the health practitioners, who are mostly expatriates, and improving their performance as well, the present study has addressed all the separate issues identified from the literature. Models of strategic plans to improve performance of health practitioners were sought. Two models were found, which included (a) the Nursing Quality and Performance Improvement Plan (NQPIP) of Vanderbilt University Medical Centre (2010), which presented six recommendations for improving healthcare quality and safety through the framework of nursing, goals, objectives, and strategies; and (b) the MOH Strategic Plan of Lebanon published in January 2007 (Saudi Ministry of Health, 2017).

### **5.2 On the Profile of Health Practitioners**

Demographic characteristics like profile of employees have major influence in the leadership that contributes to organizational success. Although a knowledgeable and skilled leadership should be

taken into consideration, the organization continues to face many leadership challenges. Such challenges affect the quality of services in the organization in terms of good output and productive management that embodies a good feedback from customers. Good governance determines group success if focused on organizational outcome. These are true in any organization including health care facilities like hospitals with the end of achieving satisfaction illustrated as the extent of a client's/patient's experience compared with his or her expectations (Pascoe, 1983).

The attainment of good governance in the organization like a hospital or health care facility starts from having a strong staff to carry out the different works and the mission, vision, and goals, which the organization has set for their existence and operation. This means that identities and profiles of every staff member in an organization is necessary. These are in the custody of the office of Human Resources. Data contained in the individual records of the staff provides ready information for management about their socio-demographic characteristics as well as a reference in staffing and making development plans in human resources among others. When such things are done and implemented, it results in better status of the staff members who are the health care practitioners, as used in this study. The profile of the health practitioners used was limited in terms of collecting data on their sex, nationality, age, number of years as health practitioners and educational qualifications. These were chosen because they are vital in the design of strategic plans, which this study aims to prepare.

### **5.2.1 Gender distribution of health practitioners**

In this investigation, both the health workers and health managers are predominantly females and a greater number come from other Asian countries. This is in agreement with the report by Lehmann and Sanders (2006) about the global profile of health workers made under the auspices of the World Health Organization (WHO). They found that in the 17 articles used to gather information about gender of community health workers, 70% of them mentioned that females dominate in number, 12% stated the presence of males while 18% did not mention genders of these workers. The same report stated that it was only in Somalia where most health workers are males.

In the study by Dimabayao (2002) about transcultural nurses in Burayda, Al-Qassim, Saudi Arabia, the author revealed that the majority were females. In England, it was noted, from the records of

the Department of Health in 1990, that in 1988, only about 9% of the total numbers of qualified staff working in the National Health Service (NHS) were males and around 10% have been reported for male nurses for more localized studies by the NHS (Davis, 1995). This implies that the majority of the nurses were females.

From these supporting literature, it is apparent that the health care profession is a female-dominated profession and this female predominance in nursing is universal in nature and has been a truth since the time Florence Nightingale opened her nursing school in 1860 after the Crimean War in 1956 (McDonald, 2010). The exception was found in the research data by Lehmann and Sanders (2006), in which the authors noted that most nurses in Somalia are males.

The admission of males in the health care profession, particularly in nursing in Saudi Arabia, is brought about by circumstances and in accordance to schools giving education and training to nurses in the future. A reason for their presence is religious in nature particularly in Islam, the predominant religion in Saudi Arabia. Female health practitioners cannot touch male patients because of gender segregation (Al-Osimy, 2004; Donahue, 1985), religious, and social norms. Hence, a male is needed. In fact, the first formal training of nurses in Saudi Arabia started in 1958 and this was for males only (Tumulty, 2001). However, a male health practitioner can attend to the health needs of a female patient provided a male member of the family is present. These things happen in a very conservative Islam country like Saudi Arabia and thus explain the low admission of Saudi women in nursing schools since 1961 when two more health institutes included nursing training programs (Tumulty, 2001). The opening of the first Nurses' Aide Program for female elementary school graduates was not favoured by parents and students from the start (El-Sabanary, 1993). This avoidance was because they believed that the program was a preparation of females to work with males and that they will be out of the home for long hours. As nursing education progressed, female enrolment also increased. The Ministry of Health was responsible for these schools. The Bachelor of Science in Nursing (BSN) program was introduced in 1976 and the Master of Science in Nursing in 1987. When nursing education and training was transferred to the Ministry of Higher Education, all other programs for nursing education lower than bachelor's degree were stopped; this happened in 2011.

### **5.2.2 Nationality of health practitioners**

Foreign workers are more in number compared to their Saudi counterparts. The imbalance of number between Saudi and non-Saudi health workers is brought about by the situation in the past when there were few institutions in higher education offering programs in allied health sciences in Saudi Arabia. Although university education became the task of the Ministry of Higher Education in 1975, courses in allied health remained very rare. This was confirmed in a report by the MOH that in 1418 H (1997AD) there were 32 health institutions that graduated 272 students in the health professions. Al-Mulhim and Al-Kuwaiti (2002) also mentioned that the Ministry of Higher Education established the first College of Applied Medical Sciences in King Saud University in the year 1402 H (1980 AD). A similar college was opened in King Abdul Aziz University after that. In 1415 (1994 AD), colleges were opened in each of King Faisal and Um Al-Qura universities. They said further that the need of the kingdom for the allied medical professionals is about 130,000 but only 30% of that are Saudis. The population of Saudi Arabia was estimated in July 2013 to be 29,939,583 and this included 5,576,076 non-nationals ([indexmundi, 2016](#)). However, the country depends heavily on expatriate staff attributed to a very low labour force participation rate of Saudi women because of cultural and religious barriers and this is seen in the data collected (Ball 2004; Mitchell 2009).

Most of the expatriate health practitioners in Saudi Arabia come from the Philippines, India, Egypt, Pakistan, and Jordan (Dimabayao, 2002). In the book edited by Connell (2008), the author pointed out that Saudi Arabia recruits labour mostly from America and Europe for hospital administrators, doctors and head nurses; Philippines and Egypt for registered nurses, and Sri-Lanka and Pakistan for unskilled jobs.

From these facts, apparently, the trend or situation of having expatriates in health workforce in Saudi Arabia, particularly in the Jazan area will not change very soon even though Saudi Arabia has its Saudization or nationalization policy. This is because the population in Jazan in 2010 ranks sixth (1,332,262) compared to other regions, despite its being the second smallest region in the kingdom and also ranks sixth in terms of its Saudi population (Salam, 2013). With this, there is a high nurse-patient ratio (1:6/8/10), as revealed by interviews to amplify the findings shown in Table 10 regarding staffing and work schedules. Furthermore, healthcare development in Jazan

region with the building of more healthcare facilities also has been on the rise since 2012 (Rasooldeen, 2012).

### **5.2.3 Age characteristics**

As to the ages of health practitioners in this study, it was found out that both groups predominantly are in the young age cohort (20-29 years old) for professional health workers as many will have only recently qualified from their diploma's. However, the health managers are younger in average age (28 years old) compared to the health workers (31.17 years old). The age difference based from the mean is 3.17 which show that the gap is not very wide. This mean age indicates that they are in their early adulthood. In the report made by Hordes Research (2005) regarding men in nursing they revealed that generally, their average age was about 44 and the largest group were between 45-54 years. However, in the study by Yamada (2002), she found out that home care aides today are generally younger in age. This can be attributed to the curriculum they have gone through. In other words, those who have finished a Diploma in Nursing/Midwifery had shorter years of study compared to those who finished a bachelor's degree in Nursing/Midwifery. When graduates of these two curricula get employed, practically, their work will be similar. They will only differ in the breadth and width of theoretical knowledge they obtained during their pre-service training.

The findings (see Table 2), showing that health managers are younger in age than the health workers can be brought about by the recent developments in Saudi Arabia by encouraging health practitioners to pursue professional growth in terms of formal education, especially among the Saudi nationals. Scholarship grants are awarded to them if they wish to pursue graduate studies. Hence, when they go back to work, they usually are designated as managers. In addition, it can be noticed from the health workers that as they advanced in age, their number decreases. This can be attributed to their decision of going back to their own country for good or may have transferred to another employer outside of Jazan region. It may still be in the kingdom or in another country.

The study by Pychyl (2010) showed relationship between age and work performance using the Behavioural Approach System (BAS). They used mostly (56%) females whose average age is 31 years old and with full time and part time jobs. The results showed that the BAS is highly related

to higher goal orientation that influences work performance. Most importantly, the relationship is most effective in contexts where work climates are perceived as rewarding. In other words, employees within that age group are individuals who are sensitive to rewards, approach success and thrive best in an organization that clearly provides rewards.

Three considerations can be deduced from the finding of Psychl (2010) in relation to this present work. First, the health practitioners used in this study have average age younger than 31 years old. As such, their goal orientation is low which is contrary to the findings of Psychl (2010). Second relevance is gleaned from the finding that performance is most effective when work climates are perceived rewarding. It came out in this present work that the health workers were generally “Uncertain” about remuneration, recognition and benefit (see Table 9), “Uncertain also on staffing and work schedules (see Table 10) and “Uncertain, too on staff development. Therefore, they cannot work effectively. Third and last, the findings imply that policies of the MOH in Saudi Arabia should be revisited to provide a better work climate to the health workers. It is on this point why Herzberg’s or Two Factor Theory is chosen to support the strategic plan to be developed by the researcher.

#### **5.2.4 Number of years as health practitioners**

As regards their number of years as health practitioners in Saudi Arabia, most of them have been in the service between 1-5 years as the modal for health workers while it is between 6-10 years as modal among the health managers. Although there were those whose number of years in the service is longer and had reached up to 21 or more years, the frequency is decreasing. This could be attributed to the fact they are already advance in age. Hence, they went home to their native lands. As also observed among others, some health practitioners leave the kingdom and sought employment in other countries. This is always the consequence when a health practitioner does not have his/her contract renewed.

The average number of years in the practice of profession by the health workers was 6.92 years. This is lower than the average number of years in the service by the health managers, which was 12.63 years. This implies that the health managers have been in Saudi Arabia as health practitioner longer than the health workers. As a matter of practice in human resources, among others, number

of years in the service is one of the criteria considered in making promotions. More senior staffs with a very commendable performance are usually candidates for being designated s health managers.

Again, this finding is supported by the findings published by Hordes Research Group (2005). They revealed that majority of the RNs surveyed (54%) have over 10 years of professional experience. On the average, these RNs surveyed by them had been in the profession for about 14 years. The modal is between 5-10 years of experience (23%) followed by 10-15 years experience and 20-25 years (16%).

The importance of considering the number of years in the service of these health practitioners relates to its effect on communication with patients and clients. Because they are relatively new in Saudi Arabia, this implies that they could not yet fully speak the Arabic language, particularly those who come from non-Arabic speaking countries. Hence, they used mixed English and Arabic in communicating with patients or clients and with their colleagues. Languages spoken by foreign workers in Saudi Arabia include Tagalog (Philippines), Rohingya (Bangladesh), Urdu (India and Pakistan) and Egyptian Arabic (Egypt).

Communication in the healthcare profession is very important, and even more so in the ward due to the frequency and importance of nurse-patient interaction. The use of language understood by both patient and nurse contributes to an effective nursing performance. Effective communication also allows the nurse and other health workers to make precise and objective assessments of the patients' conditions.

#### **5.2.5 Educational qualification**

Educational qualification is probably the first criterion looked into by employers whenever they recruit new staff or personnel. Most of the healthcare practitioners were found to have earned a Diploma in Nursing or Diploma in Midwifery (see Table 5), which implies that the knowledge and skills they acquired are not as intensive as those who have obtained higher levels of education such as those who finished a baccalaureate or a master's degrees. Number of years required in obtaining a Diploma are usually fewer compared to a bachelor's program and the curriculum is different. As

such, most of the staff nurses are charge nurses, who fail to progress to nurse management because of their educational limitations.

The study by Al-Hamadi (2009) revealed that work performance was positively correlated with personal and professional variables. The same finding was found by Yaghoubi, Javadi and Bahadori (2013), supporting that there was a significant relationship between performance and level of education. Since most of the health practitioners earned a diploma in Nursing/Midwifery or Diploma in Midwifery, these findings show the importance of providing continuing education in order to upgrade the present group of health workers with higher level of knowledge, skills, and finally, their performance. It also means that future staffs, health workers, and health managers to be appointed and recruited should have educational qualification higher than a Diploma or with a Master's degree. This is another instance that a strategic plan to develop the health practitioners is seen necessary. Providing them with continuing education is important to keep them abreast with recent knowledge and practices in the profession. Hence, the Human Capital Theory and Constructivism Theory would support this endeavour, as human capital theory supports education as a process of human formation and economic investment to support individual and societal growth and constructivism contends that knowledge furthers individual development in terms of cognitive development.

### **5.3 Assessment of Health Practitioners on Workplace and Incentives**

This section of the study is a discussion of elements that are deemed to affect work performance. It was limited to utilisation of performance appraisal; remuneration, benefits and recognition; staffing and work schedules and staff development.

#### **5.3.1 Utilisation of performance appraisal**

A concrete and tangible feedback about how effective and efficient a particular employee does her role or job functions is through performance appraisal. It is a tool used in human resources that contains a set of criteria, which the company or workplace wants to measure.



Results of this study showed that the health practitioners were agreeable (see Table 8) to all the items regarding utilisation of performance appraisal in their organization or unit (Mw=3.66). The statements provided therein as to the utilisation of the tool are indicative that they are done by the evaluating personnel. For example, the statement with highest value (MW=3.92) was on knowledge of objectives to be achieved are known by individuals to be assessed. When the researcher asked as to how they were you provided with the objectives to be assessed, they said they were sometimes called for a meeting after a memorandum is issued; sometimes they personally asked for further clarification about the objectives after the notice of having performance appraisal was issued and their fellow health workers informed them because they were not on duty when the conference was called. From these responses, it could be deduced that the health workers experience several ways of knowing the objectives of the performance appraisal.

These responses suggest that the health practitioners have a positive outlook on the purposes why performance appraisal is being done. Their willingness to know the objectives of the appraisal is an indication that they want to understand it well so that they can give the best responses as needed. Furthermore, it implies that they understand the purpose of performance appraisal and are amenable to innovations and advising as a consequence brought about by the result performance appraisal. For example, when one is found to have knowledge deficit in Arabic language, one stated that they try to inspire this staff to the best. Besides, language is very vital in documentation. This is a form of constructive feedback done by health workers to the staffs. As a charge nurse, she is responsible in the day-to-day activities in the ward and she should see to it that staff nurses in that ward do well. This finding aligns with prior research by Fort and Awases (2004), who contended that performance of nurses and midwives is strongly related to receiving performance feedback.

Some of the health practitioners expressed also the belief that performance appraisal in their work is not only done through the use of the formal tool. At times, there are instances when an immediate report or feedback of performance is made, particularly on those which do not give satisfactory results. As it was noted from the finding (see Table 8) the statement with lowest weighted mean value, but still within the range of “Agree” was on giving constructive feedback on performance

appraisal results as provided on a regular basis. The employee or employees concerned is/are called for a private meeting to discuss the problem. Hence, the action made is immediate and therefore resolves the problem. The point is put on improvement of performance. This approach makes them confident in the job because they feel respected. One instance is the point when a health worker was asked to explain why she rated herself on “exceeds expectations on knowledge of work”. After explaining that she learned them during her training, the manager expressed respect and even inspired her that if she can do better in the coming days, it will be appreciated. This also suggests that the leader or manager motivates staff under her. This is a key finding, as it is supported by Omprommorat and Sriruecha (2013), who found that when there is high motivation to work, there is also high performance.

### **5.3.2 Remuneration, benefits and recognition**

This is the monetary equivalent of the services due to employees like the health practitioners. To some employees, these are considered motivators. While it was found out from the survey that the health practitioners agreed that their salary is competitive compared to other organizations and that experience and job responsibility were also considered, there were also instances noted where they expressed to be uncertain. These were on knowledge about their fringe benefits, their satisfaction about their fringe benefits as well as their opportunities for advancement and recognition for hardworking employees.

Along this view, Herzberg (1987) stated that there are psychological needs which he referred to as hygiene factors, which an individual want and expect to be fulfilled. These factors refer to pay or salary, fringe benefits, physical working conditions, status and job security. He said further that when these are not met, it results to dissatisfaction. This happens when the employee believes that he or she is not paid fairly based on the nature of work and work conditions. Although fringe benefits are different from salary, yet it is important that the employer should inform the employees about this. This can be done commonly in two ways; 1) it can be verbalized to the would-be employee during the recruitment process, and 2) it must be contained in a manual or any similar document of the company.

Similarly, the same source (Herzberg, 1987) pointed out that recognition, advancement and growth lead to satisfaction along with achievement, work itself and responsibility. In this study, there were two who had a master's degree and about 19 had a bachelor's degree (see Table 3). This is considered advancement and growth. In this case, the health workers were designated to the job because their advancement in education was recognized and it provided them with improved ability and performance. This justifies why the health workers agreed on the statements that remuneration are in accordance with experience and with job responsibility (see Table 7). When employees perform well in the job, they may get promotions in designations. If this happens, there is increase in remuneration. Hence, it improves the morale of the employee in the job.

### **5.3.3 Staffing and work schedules**

There are certain limitations that a certain company does when it comes to staffing. First and above all, a company operates based on budget allocations. That is why the employees feel the company, like health care facilities, is under staffed when they have plenty of clients to attend to. In this instance, there is a dilemma on the part of management as to whether it would limit admission of clients or increase budget allocation for additional staff. This is the reason behind why the health practitioners always see that there is always shortage of staff (Dimabayao, 2002; Pallot, 2011; Almalkhi, Fitzgerald, and Clark, 2011). Although there is truth of the matter, this situation implies that management should consider population growth as a factor in the shortage of staff.

### **5.3.4 Staff development**

Any or all staffs in any workplace need to grow and develop. This is to keep them abreast with current trends and practices in their profession (Lucas, 2014; Ruder, 2013). Employees in healthcare facilities are not spared from this. With this, it is an assurance that these facilities could provide satisfactory services because of quality performance. Apparently, the health workers used in this study were generally uncertain as to how staff development is practiced in their respective workplaces (see Table 9). This means that they are not totally sure of whether or not those statements used in the appraisal for staff development are used, done or applied. In other words, the health practitioners are not totally aware as to how the health facilities where they are employed develop them. However, they agreed that necessary training should be given to ensure effectiveness. They also agreed that health practitioners should participate in identifying their

development needs. This finding is collaborated by Metcalf (2001) when she discussed the importance of performance appraisal and staff development for graduate nurses. This is necessary especially that the health practitioners mostly have Diploma in Nursing/Midwifery as educational qualification (see Table 3).

Providing the health practitioners with training for their development is backed up by the Human Capital Theory by Ngwu. This theory according to Marshall (1998) considers education as highly essential to the development of the productive capacity of human workforce which is a form of capital investment that brings economic gains or returns to the individual and society.

#### **5.4 Factors Affecting Work Performance**

There can always be factors affecting work performance. This is brought about by differences in training, abilities, application of knowledge and attitude. As it was revealed in the survey, six instances surfaced as major factors. The rest or most were intermediate factors. Even though they are intermediate factors affecting performance, they should not be relegated to the background for they may become worse which will later affect the quality of care and services.

##### **5.4.1 Major factors.**

There were six factors (see Table 10) found to affect work performance of the health care practitioners. They are discussed individually in this section.

###### **5.4.1.1 Shortage of staff.**

Foremost of the major factors found to affect the health practitioners' work performance is the shortage of staff. This finding is in agreement with findings of Dimabayao (2002), Pallot, 2011) and Almalkhi, Fitzgerald, and Clark (2011) also conducted in Saudi Arabia. Apparently, this is not only in Saudi Arabia but also in other countries. This was cited in the works of DeLucia, Ott, and Palmierie (2010). When there is shortage of staff in a hospital, there would always be stress among them. In addition, shortage of staff can result to longer working hours. It is because there are no available ones to takeover after their supposed regular working hours. These were noted during the interviews with the respondents. Respondents commented that staff nurses are requested to forego their days-

off, or have the days off carried forward to a later date, which will impact on their stress and fatigue levels and ultimately could affect patient care.

Shortage of staff in Saudi Arabia, as pointed out in the study by Almalki, Fitzgerald, and Clark (2011), is an issue that challenges the healthcare system. Shortage of staff in Saudi Arabia has been noted even in the 1970s. The work by Sebai (2007) presented this fact and situation and he pointed out that the reason for not being able to address the problem is due to lack of strategic planning. As a consequence, the alternative was to hire expatriates as staff (Pallot, 2011), who make up more than 85% of the country's healthcare system. After more than a decade, based from the study by Dimabayao (2002) the situation is still the same (see Table 10). This implies that patients or clients utilizing government facilities in Saudi Arabia are many, and that shortage of staff always remains as a major factor affecting work performance of health practitioners. This could be attributed to the high demand resulting from free services as stated by Almalki, Fitzgerald, and Clark (2011). Consequently, if a staff nurse, or any health worker for that matter, is stressed, then performance is affected, which, in turn, affects the satisfaction of patients and clients about the services provided. This statement is supported by Al-Makhaita, Sabra, and Hafez (2014) when they revealed that one variable having significant predictive effect to performance of nurses was stress. Thus, it can be said that an individual can only do so much if quality and effectiveness is desired. Shortage of staff in health care institutions can be the effect of absence of sufficient manpower available whom possess the desired qualification for the job; too many clients or patients resulting in a high nurse-patient ratio as learned from the samples during the interview.

#### **5.4.1.2 Inefficient staff.**

Inefficient staff, found as the second major factor (see Table 10), highlights the effect of long working hours. It was learned during the interviews that there are times when staff are requested to forego their day-off because of shortage of staff. As such, inefficiencies in the nursing work system result in task overload of nurses (DeLucia, Ott, & Palmieri, 2010).

Inefficiency among staff can also be the direct consequence of their educational attainment and lack of training. Yaghoubi, Javadi, Rakhsh, and Bahadori (2013) concurred when they revealed a significant relationship between performance of nurses and level of education. Their sample included nurses with post-graduate education. In this study, most of the health practitioners have finished Diploma in Nursing/Midwifery (see Table 3). Obviously, health practitioners whose educational background is shorter have received less training and demonstrate less knowledge compared to those with longer curriculum requirements to finish the course. However, in the study of Al-Hamadi (2009), level of education was negatively related to performance of hospital nurses in the Riyadh region.

From the prior research, developing the staff to improve their competencies is important and necessary through continuing education. Alkhazim and Althubaiti (2014) noted that these variations can be attributed to education, training, and practice in their country of origin. This is why they acknowledged the importance of continuing education in improving knowledge, attitudes, and clinical and academic skills as well as improving clinical outcomes.

#### **5.4.1.3 Inefficient leaders.**

Presence of inefficient leaders was also found to be a major factor contributing to affecting good work performance (see Table 10). This is brought about by the fact that most of the health practitioners have finished Diploma programs, which implies having had a short educational experience (see Table 3) and being young in the service (see Table 6). These situations support the notion that there is deficit in leadership knowledge and skills. Each individual has his or her own leadership style. The individual practices the style that he or she has learned. Sometimes, it comes out spontaneously as the need arises. Subordinates who expect much from the manager, in so far as carrying their work is concerned, may see the leadership of his manager as weak. It is at this juncture that the manager's leadership style is considered to be a factor to affect worker performance. Although it is true that workers, like the health practitioners in this study, are expected to know well how they perform their duties, these health practitioners still wish to be given more and better ways of doing their work through the guidance of those who hold higher designations. This is

especially true in Saudi Arabia, because most of them are new in the country (see Table 6) and that they encounter communication (or language) barriers and cultural differences (see Table 11). The researcher sees this as necessary and important to help the new health practitioners to develop self-confidence in the new environment.

With this as a premise, Frankel (2008) said that leadership roles are different from management roles. Her statement was drawn from the book of Covey (1999), citing Peter Drucker's statement as "management is doing things right; leadership is doing the right things" (p. ). It is on this fact that the health practitioners long or desire to experience with their managers. Hence, they consider the leadership style of their manager to be a factor affecting their work performance. As defined by O'Grady (2003), leadership is a multifaceted process of identifying the goal or target, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals.

If leaders are inefficient, then they may well have inefficient staff as well.

In the health and allied professions, leadership is very important. Its importance is underscored by Anderson (2013) when he said that all nurses are leaders and managers at some level.

From the qualitative data, when asked why the health workers need to use pragmatic management, many of their responses were HM 5 "*So that we can make actions immediately with least consultation from higher leaders*" and "*So that we can make decisions according to our observations*". This now confirms the finding that inefficient staff and inefficient leaders (see Table 12) are major factors affecting their performance. Decision-making is silent in the roles or job functions of health workers. Therefore, if providing them training on leadership skills and management, they would be able to manage their areas better and that is what they mean about fair management. Consequently, they would be able to provide quality service and better work performance. This is where Oregon Theory, Human Capital Theory, Constructivism Theory (see Figure 1) are useful in this study.

#### **5.4.1.4 Benefits (sick leave and others).**

Benefits, like sick leave, were also found to be major factors affecting the work performance of health practitioners. There are two instances supporting this factor as affecting the health practitioners. First, the practitioners cannot access sick leave benefits if they are not actually sick. Second, the number of days is not cumulative, which means that unused sick leave is not carried on to the next year.

#### **5. 4.1.5 Staffing system.**

Staffing system as a major factor affecting performance (see Table 11) can still be attributable to shortage of staff. It was learned from the health workers that there are many instances where changes in work schedules happen. During the interviews, the health workers expressed situations of times when they are asked to forego their dayoff due to staffing issues. This results in dissatisfaction of employees. This finding was in agreement with the findings by Almalki, Fitzgerald, and Clark (2012), who found that among the causes of dissatisfaction among nurses are unsuitable working hours and poor staffing.

#### **5.4.1.6 Undefined policies and procedures of the organization.**

Organization in management is desired to bring about good results. However, if policies and procedures are undefined, then these can be major factors to affect performance. Problems related to policies are localized which means that the nature of problems encountered in one hospital is not the same in another hospital. When such things happen, the manager of the hospital handles the solution of the problem. One example offered by the interviewed health care workers in this study of a commonly found undefined policy was the “pending-off” which makes the health workers forgo their supposed day-off. Nurses who experience this are not given overtime pay. This happens when a staff member has a sick leave or goes for a holiday/vacation. Another example is salary scales; the salary of an expatriate is different from a local or Saudi, even though they are in the same category.

#### **5.4.2 Intermediate factors:**

Although the other factors felt to affect work performance noted from the health workers were intermediate in nature, these intermediate factors remain crucial to work performance



because, if neglected, these can become major factors. Any small thing becomes bigger and worse if unattended. In this case, satisfaction of patients will be affected.

#### **5.4.2.1 Patient satisfaction and feedback.**

Patient satisfaction and feedback was found to be among the intermediate factors to affect performance in this study (see Table 11). The health workers noted patient dissatisfaction related to total nursing care. This is contrary to the findings previously found by Al-neami, Dimabayao, and Caculitan (2014) that the inpatients at King Fahd Central Hospital in Jazan were generally satisfied with the nursing care provided by the nursing staff. Al-neami et al. reported dissatisfaction expressed among the inpatients from paediatrics only. The difference in findings can be due to the magnitude of the study, as the study by Al-neami et al. was limited to a single hospital, while the present study was conducted in several hospitals and health care facilities in Jazan. Al-Doghaither (2000) revealed that the lowest score on satisfaction level of 450 inpatients from different wards at King Khalid University Hospital in Riyadh was related to communication. Al-Doghaither noted limited communication between nurses and patients, which was attributed to cultural and language barriers. In this present study, language barriers and cultural differences were also noted as intermediate factors to affect the work performance of nurses (see Table 11). This is the effect of having too many expatriates (see Table 2) working in health care facilities, for which their native language differs much from the host country. In addition, Al-Doghaither revealed that the male patients were mostly dissatisfied with most of the nursing care provided to them. Again, this is an example of the effect of cultural barriers. There are limitations for female nurses in performing some healthcare work to male clients.

#### **5. 4.2.2 Coordination with other health personnel and teamwork.**

Coordination with other health personnel becomes a problem especially in the emergency room and medical and surgical wards. In the emergency room, some cases require the assistance of other health personnel. A patient admitted due to cardiovascular accident needs a medical laboratory technologist to take a blood serum for examination. An X-ray technician may also take an image of the heart. When this was verified from the health care practitioners, they interpreted coordination issues not as the lack of coordination, but as

issues with the time needed to obtain examination procedures and results. These time issues cause delays in performing other procedures and in timely decision-making, and thus teamwork is able to be seen to be either poor or strong. Broome and Marshall, (2016) maintain a cohesive team is necessary to promote patient health, safety, and recovery. It is said that the culture of teamwork and attitude are important in the success of doing a job (Ward, 2013). This is akin to the saying, “*in unity stand, divided we fall.*” In this particular study, the problem related to teamwork is not in the absence of teamwork, but in the urgency of availability. In other words, the health practitioners are unavailable to do a certain task during the time they are needed. There are constant delayed responses to calls and requests. It could be inferred that this could be caused by shortage of staff and that they cannot simply put down or leave what they are presently doing when a call or request is made. This is a situation that can be resolved. One type of teamwork problem is the type of organizational or structural problem (Ajejbge, McNeese-Smith, Phillips, & Leach, 2014). In this situation, teamwork problems occur when goals are not clear, responsibilities are not clear, people with the wrong talents are on the team, the challenge is too big for the team, there is little or no communication, and more (Ajejbge et al., 2014). It was pointed out in earlier discussion that undefined policies and procedures of the organization constitute major factors noted to affect work performance (please see 5.12.6). These issues in teamwork can be overcome by the team members themselves and management. Although it may take some time to solve the issues surrounding teamwork, with the aid of supervision, solutions are at hand.

#### **5.4.2.3 Cultural differences.**

Cultural differences were revealed as an intermediate factor to affect performance of health workers in this study. However, when the respondents who were new in the service and in the kingdom were asked, their responses were very serious, thus considered a major factor. These participants said there was culture shock from the start and that was during their first encounter. But as they gained experiences, they were able to adjust to the cultural differences. One such experience cited was a married woman escorted by her husband during prenatal check-up. These cultural differences are also true in physical therapy. This

was supported by Walton (2007), who conducted a study about health beliefs of Muslim women in the United States. Walton disclosed that Muslim women (a) preferred to have female physical health care providers; (b) were more willing to access physical therapy services if provided by a female, but often not when provided by a male physical therapist, and (c) comfortable with the use of physical touch in physical therapy evaluation and treatment if the provider was a female.

#### **5.4.2.4 Adequacy of supply and resources.**

Adequacy of supply and resources was found to have contradicting results. In Table 9, the health practitioners showed affirmative responses to this factor; however, in Table 11, this factor became an intermediate problem. This point was clarified by the participants. The health practitioners revealed that “adequacy of supply and resources” refers to the stocks available in the central supply department of the hospital and health care facility, which they felt was addressed under the topic of assessment of the workplace. When the same point was presented under factors affecting work performance, it became an “intermediate factor” because consumables and disposables are released according to how much is needed and how many patients are requiring such supplies and resources. In short, the release of supplies is proportionate. However, there are instances when the released supplies run short because there are more clients who need the same supply, requiring health practitioners to go back to the central supply room. Analysis of this matter showed that it was not actually adequacy of supply and resources that affected the performance of the health practitioners but rather, the frequency of turnarounds. Having many turnarounds affects time in accomplishing the work. In most instances, this happens when personnel assigned to do the work do not have a clear policy on how resources and supplies can be taken.

#### **5.4.2.5 Language barrier.**

Language barrier is undoubtedly a factor to affect work performance owing to the fact that most of the health practitioners are expatriates (see Table 2) and are relatively new in Saudi Arabia (see Table 6). This group of health workers expressed that they have learned to use some Arabic words, especially commonly used words and phrases, to support work

performance. In most instances, the participants in this study described using the English language to communicate with their peers and other employees of the hospital. The health care practitioners disclosed that talking to locals who have no understanding or less background with the English language is a very serious problem. However, the assistance of a more senior peer in the setting reduced the problem. Hence, responses resulted in language barrier as an intermediate factor only. Again, results offered by Al-Doghaither (2000) support this finding with evidence that the lowest satisfaction score among 450 inpatients from different wards at King Khalid University Hospital in Riyadh was for communication. Al-Doghaither acknowledged limited communication between nurses and patients, which was attributed to cultural and language barriers.

#### **5.4.2.6 Proper communication skills.**

Effective communication skills are necessary in the workplace for all staff to maintain good patient care. When working with patients, especially in the wards, it is necessary and important for the health worker to introduce his or her name during their first encounter during the day. This supports patient confidence and feeling relaxed. Introducing oneself to patients is necessary because the patients are being attended to by different health workers throughout the day. Again, due to the fact that most of the health workers both are new to the kingdom and have a language barrier, communicating with patients is regarded as a factor to affect work performance.

In addition to nurse to patient communication, nurse to physician communication is also very important. It determines safety and quality of care. Because of nurses and physicians have many patients to attend to these two health care practitioners often lack adequate time to support effective communication. It requires the skill of the nurse to be cognizant of the possible and more effective care and interventions for the patient so that these can be consulted with the physician when he or he is available. According to Shannon and Myers (2012), the problem of ineffective nurse-physician communication is both common and complex. This is why they recommended three solutions to overcome the problem. These solutions include (a) improving organizational culture; (b) using structured communication tools, and (c) linking the communications platform with secure, effective communication

tools. Shannon and Myers contended that these solutions would address the many communication gaps that thwart effective nurse-physician communication.

#### **5.4.2.7 Appraisal of personnel.**

Appraisal is a means to acquire feedback on how personnel have performed their tasks using a certain tool prepared by management. Some of the health workers interviewed for this study regarding this aspect expressed that the tool used contains some items that are broad and very general in nature. As a result, the participants described some apprehension that they might not be rated fairly, therefore affecting their performance. Thus, they considered appraisal of personnel to be a factor to affect their performance. Relative to this, it has been noted that “bosses avoid the truth in annual appraisals” stating that “effective performance appraisal can bring out the best in each employee, and create a strong link between individual performance and the achievement of organisational goals. Appraisals are also a powerful motivator, providing opportunities for praise, feedback, and development. Despite these benefits, research shows that appraisals are not without problems, as 30% of employees think they are waste of time” (Rowlands, 2008, p. 1). Rowlands (2008) also stated that everyone has their own thoughts, beliefs and assumptions and these can often affect the performance appraisal process through unfair bias, prejudice, and stereotyping. Personal bias can originate from employee’s age, gender, religion, ethnicity, disability education, and more. One example of bias given to impact appraisal ratings is the belief that young people work more efficiently than older workers.

This implies that health practitioners need some form of orientation before the accomplishment of performance appraisal or when the period of performance appraisal begins. This would make them aware of how they would be rated and how the appraisal would be done. In this way, apprehensions are eliminated and the employee may perform well all year. This finding supported prior research by Pfeffer (2009), who concluded that making performance criteria explicit and objective reduces managerial discretion so that a person’s perceptions and biases don’t matter as much.

#### **5.4.2.8 Remuneration.**

Employers set criteria as to remuneration equivalent to educational qualification and designation or nature of work. Among others, basic salary, experience increment, and maximum scale of salary make up the total remuneration due to health care practitioners in Saudi Arabia. Accommodation is provided by the hospital and health care facility. A unique advantage of employment in Saudi Arabia is having salaries tax-free. In addition to their salary, contract workers are awarded an indemnity at the end of the contract period. The indemnity is based on the value of the entire remuneration package including performance bonuses (where applicable).

The fact that income in Saudi Arabia is tax-free is still a factor affecting these health practitioners. For example, one reason the health workers considered remuneration a factor in work performance is because overtime work is not paid, which was expressed by the participants during the interview.

#### **5.4.2.9 Job commitment.**

Job commitment is synonymous with organizational commitment. Allen et al. (1999) defined organizational commitment as an emotional attachment to the organization's values and goals, for which the individual exerts efforts on behalf of the organization and demonstrates the desire to remain in the organization. The health workers, most of which were noted to be new in the kingdom (see Table 6), expressed several reasons why they considered job commitment to be a factor affecting work performance for them. Homesickness is not a part of the realm or scope of job commitment because it is something personal. However, if it haunts them, truly their performance is affected. The participants in this study said that they are committed to the realisation of the goals and adherence to the values of the organisation. However, their experiences in the job that stimulate stress and burnout make them consider leaving the organisation. Failure to communicate well with patients and other locals, cultural differences, and staffing (see Table 11) were common reasons noted as affecting job commitment. When these are not overcome, it may lead to turnover, further contributing to the shortage of staff.

Odoch and Nangoli (2014) found in their study that job satisfaction related positively with organisational commitment in a college in Uganda. This was somewhat expected in the sense that the setting of their study was an educational institution where camaraderie is promoted. This is different from the findings of Yahaya et al. (2012), who noted that level of commitment differs between male and female employees. Yahaya et al. said that to improve job commitment, the organisation should be cognizant to the needs and wants of the employees including taking note of their problems and that the staff should not be pushed to perform tasks that are not linked to their job description. Above all, the management of the organisation may give recognition to employees who perform well; management believed that, in this way, the staff will be loyal and have a strong feeling of belongingness (Yahaya et al., 2012). As a consequence, employees will feel that it is hard to leave the organisation.

## **5.5 Training Needs and Requirements**

One notes from the review of literature that there are many curricula implemented in nursing ranging from Diploma to Degree (Al-Hamadi, 2009; Yamada, 2002) . These differences are articulated in the number of years required to obtain them. Some are finished in three years, some in four years, and others in five years. Since healthcare facilities have specified the qualifications needed and required to do specific jobs, recruiting the required number of staff to satisfy the need seems difficult. Thus, the word “minimum” is used in looking for possible staff to make recruitment easier and faster in the hope that they will be given training and development or even continuing education when they are hired.

With the factors identified through this study that are affecting the work performance of the health workers, the leadership and management skills of the health managers are much needed. These health workers expressed that leadership and management skills among managers are moderately needed to improve and maintain excellent performance. As revealed by the survey among the health managers, only eight, or 20%, have received management training. Hence, the health workers see the need for a kind of leadership and management skills that push or enable them to perform better. If a manager has little or has a lack of management and leadership skills, the morale

of subordinates is affected. The major needs contained in this study (see Table 12) could be grouped into three areas. These groups pertain mostly to management and leadership. The others relate to attitudes that should be manifested by health managers, while the third group includes miscellaneous items needed to have good management. As shown in Table 12, these groups are:

Major needs pertaining to management and leadership:

- Pragmatic approach (fair management);
- more advanced leadership training;
- able to manage change (able to respond to change pressure of the organization);
- manager's innovative leadership; and
- using proper appraisal system.

Major needs pertaining to attitudes that should be manifested by the health managers:

- Sensitive to the needs of the general membership;
- empowerment of its officer and staff;
- fully aware of structure and policies of the organization;
- devoid of self-interest; and
- endowed with intellect and political will in governance.

Miscellaneous items needed to have good management include: English proficiency training and non-imposition of cultural practice.

The findings of Pillay (2010) concerning management skills are on different perspectives. Pillay revealed that the largest differences between the mean importance rating and mean skills rating for public sector hospital managers in South Africa were related to people management skills, task-related skills, and self-management skills. With these differences, he expressed that there is a need to improve them, too. This is the reason why the present researcher wishes to develop a strategic plan to improve not only the knowledge and skill of the health workers but also the health managers. With this plan, the researcher envisioned to use different theories to support his own. The total picture is articulate in a conceptual framework developed from Figure 1.

The qualitative interview data support this, suggesting that both health workers and health managers need trainings on management. This is to equip them with better knowledge and skills



in the field. Furthermore, their educational attainment (see Table 5) has not provided them much about this and that many of them are young in the service (see Table 6).

## **5.6 Involvement of Health Managers on Management Tasks**

The health managers were found to have been often involved on management tasks. However, orientation of new staff and providing continuing education to employees were noted as the management tasks where they were always involved. This is an indication that they have high sense of responsibility in developing and providing competencies among the staff. This is in agreement with the results of the study by Alkhazim and Althubaiti (2014). They said that healthcare practitioners acknowledge the importance of continuing medical education in improving knowledge, attitudes, clinical and academic skills, as well as improve their clinical practice outcomes.

Managing conflict, and in particular operational conflict, are tasks that showed the health managers were sometimes involved only. This does not necessarily mean that there were fewer conflicts in the workplace. This is more attributed to the educational attainment and number of health managers who have attended management training. Only 2 or 5% of them have a master's degree (see Table 5) and only 8 or 20% have attended management training as expressed by them during the interview. Hence, most of them do not possess the necessary skills in management. As a consequence, conflicts cannot be addressed according to the expectations of the health workers. The investigator asked the health workers, "How does the health manager deal with conflicts?" Most answered that the health managers would ask them: "What do you think is best for us to do?" This is an indication of consultative management, which is a good management practice. Solutions to problems come from the health workers themselves. In this instance, the health manager does not always give any input. This is the reason why the health managers are sometimes involved in managing conflicts.

The above statements differ from the findings in the study by Dolan (2003) on management style and staff nurse satisfaction. She conducted the study with a sample of 98 nurses whose average age was 36, all of whom held a baccalaureate degree in nursing and had worked in the hospital for

an average of 8.2 years. Dolan found that the majority of these nurses perceived that their manager practised a consultative management style. This reflects the manager's use of staff ideas and opinions and the frequent involvement of staff in decision making. With this, it justified the data that the more participative the nurses perceived their manager's leadership style to be, the more satisfied they were in the job.

### **5.7 Self-Assessment of Health Managers on their Management Skills**

The previous discussions have shown that there are some areas in which the health managers were found to be weak. Hence, there is a need to improve these areas (see Tables 13 and 14). However, these health managers assessed themselves as good in management skills (see Table 15). This is in conformity with the findings of Toygar (2013), who found that managerial skills of hospital administrators in Turkey were positively and significantly correlated with their conflict management and coaching skills.

The “good” level of management skills of the health managers came from their responses. Since this sounds self-serving, as nobody wants to “harm” himself, what the investigator did was to crosscheck or validate this from the health workers. Using the same items as was used with the health managers, the result of responses was similar. Therefore, it can be said that the quality of management skills manifested by the health managers is really good. Again, it can be opined that the health workers just made their honest response since they do not want to offend the health manager.

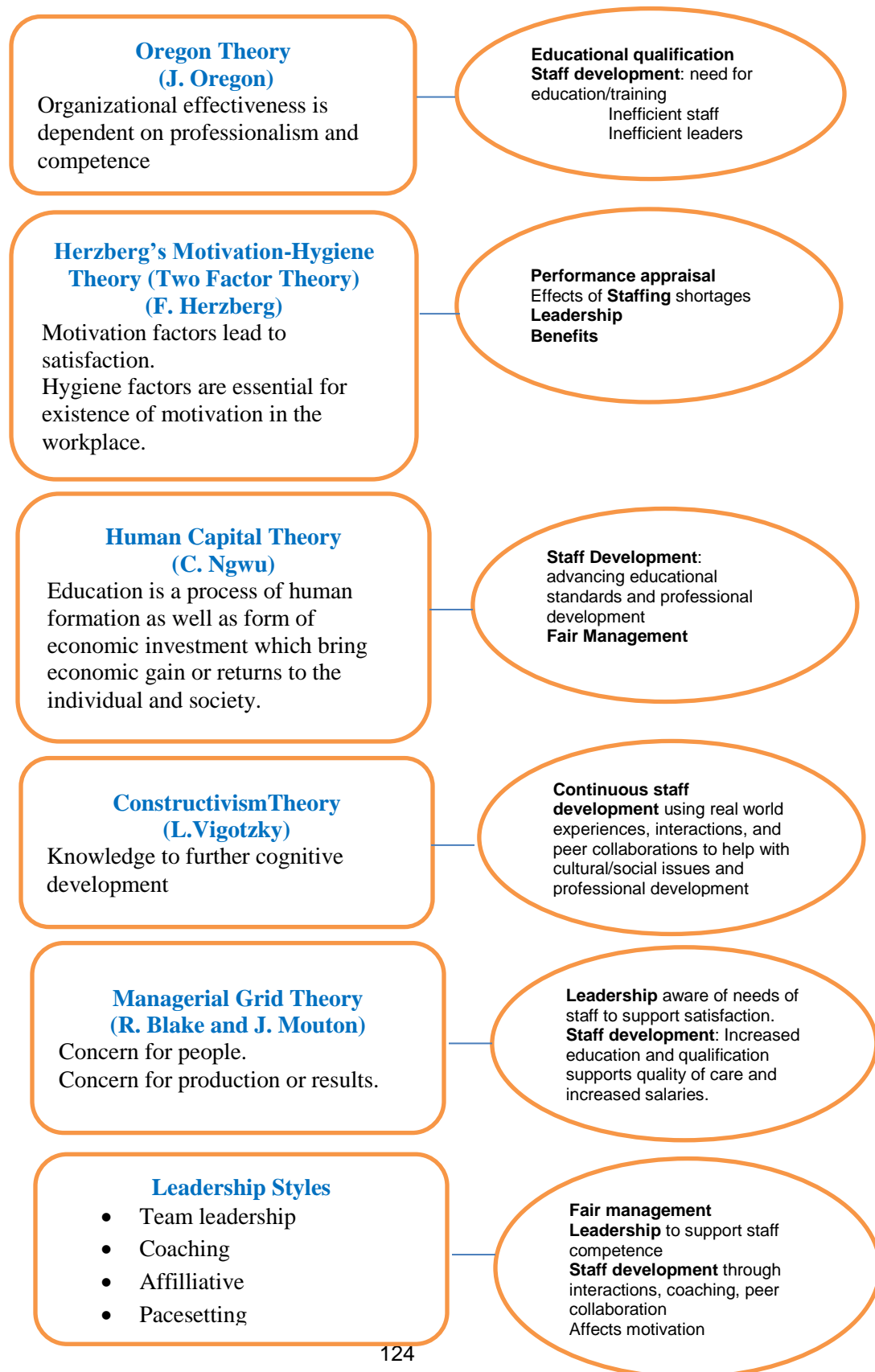
In the strictest sense on the use of the word, “good”, this is the lowest level in the degrees of comparison (as in good, better, best). Whether the health practitioners were honest or just humble or otherwise, this is indicative that both groups are aware of the quality of management skills manifested by the health managers. This implies that the health managers need trainings, too, in order to improve their management skills. For those who are given the opportunity to go for advanced studies, some of them should take specialisation on hospital administration/management. This is to have somebody who is academically trained to do the job. Furthermore, there would be somebody who will exercise better leadership in the hospital and health care facilities, not only in Jazan region but in the whole kingdom.

## **5.8 Conceptualisation of an emerging performance management framework.**

The results of the study, in the context of the various theoretical frameworks applied to the study (see Figure 3 below) provide evidence for the development of the current researcher's theory.

This new theory contends that the quality of health care service and work performance is a consequence of the status of health practioners and the nature of a program implemented.

**Figure 3. Conceptualization of emerging performance management framework.**



## **CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS**

### **6.0 Introduction**

This chapter presents the conclusions drawn from the findings from which recommendations were based. Future dissemination plans are identified within the constraints of the cultural context of the work where some results may be politically challenging and thus may not be disseminated for personal safety reasons.

### **6.1 Conclusions and Recommendations**

The aim of this study was to explore factors that influence health practitioners' performance with the objectives of

A: evaluating the profile of health practitioners and its implications to the delivery of healthcare services in the Jazan region.

B: exploring factors that influence work performance and the needs of health practitioners.

These two objectives were addressed through the research and conclusions drawn from the findings and discussion. These are addressed below and are then followed by a section on recommendations and limitations of the study.

#### **6.1.1 Conclusions in relation to objective A: to evaluate the profile of health practitioners and its implications to the delivery of healthcare services in Jazan region.**

The study indicates that the health practitioners in Jazan are predominantly female expatriates in their young adulthood composed mostly of Asians; and Saudis mostly assigned as charge nurses with an average of between 6-12 years of experience. However, these health practitioners do not have the necessary current educational attainment required in their designations.

Asian countries still remain as the highest sources of health practitioners in Saudi Arabia. Furthermore, females are still higher in number compared to their male counterparts. This also was revealed in the study by Dimabayao (2002). With this, it can be said that the Saudi Arabia

healthcare system is still dependent on expatriates (Al-Mulhim, 2013). The health practitioners also tend to have educational attainment lower than a bachelor's degree. This is brought about by the differences in the number of years required to finish nursing education. In Saudi Arabia, the training of nurses was undertaken by health colleges under the Ministry of Health; the students originally completed the curriculum in two years, which later, in 2008, became three years. This justifies the fact that even Saudi nurses involved in this study typically possessed a Diploma in Nursing/Midwifery, rather than a Bachelor's degree.

When nursing education and training was established in the university level beginning 1976, the curriculum became a bachelor's degree and the number of years to finish it is five years. All other nursing programs except the Bachelor's were stopped in June 2011 at which time it became the responsibility of the Ministry of Higher Education (King Faisal Hospital and Research Center, 2017). Considering these time elements, even Saudi nurses are mostly young in the service. In addition, the Saudization or nationalization policy of employment in the kingdom enables them to hold designations higher than a staff nurse.

It can be gleaned from the statements above that the profile of health practitioners still shows similar characteristics to those reported in previous years. As with the study by Yamada (2002), demographic characteristics of hospital and nursing home aides in this study showed little change over the decade. However, Yamada noted that qualifications improved with the implementation of health regulations, which are being recognized in schools as curricular innovations, as also is experienced currently in the kingdom.

From these results and in the context of Oregon theory, human capital theory, and constructivism, recommendations for continuing education can be formed. From Oregon theory, it can be understood that organizational effectiveness is dependent on the professionalism and competence of the staff. Building competence and professionalism through advancing educational standards and professional development are key tenants to building staff competence. It is recommended that further continuing education opportunities for staff members be provided to support advanced education and competence among the nursing staff, which will in turn support quality of patient care and satisfaction. When professionals, like the health care practitioners in this study, are

competent, they become more effective in terms of their job performance. Consequently, this competence will increase patient or clientele satisfaction. With advanced education and training, the health care practitioners will benefit from increase qualification, which translates into an increase in remuneration or salary. Because they are assumed to have been equipped with better knowledge and skills, they will provide better performance to enable a higher satisfaction level from the clienteles.

Finally, using constructivism theory to build these opportunities will include real world experiences, interactions, and collaborations to support advancement of the health care practitioner learners. With the cultural and societal context of nursing in Saudi Arabia, and that most of the health care practitioners are expatriates, collaborations among their peers and supervisors who are considered mediators, can be used to improve understanding the language and culture as well as ways of carrying out procedures and nursing practice.

#### **6.1.2 Conclusions to the objective b) : To explore factors that influence work performance and the needs of health practitioners.**

Assessment of the healthcare practitioners concerning performance appraisal and its utilisation in the organisation or unit is positively acceptable to them. However, they were generally uncertain whether they agree or disagree on the statements concerning remuneration, benefits and recognition, staffing, and work schedules. There were major and intermediate factors noted to affect their work performance, which is gleaned as the effects of the health managers' management tasks.

Shortage of staff, as the number one major factor noted in this study, is still a condition that prevails in the kingdom, aligning with previous studies (Al-Malki et al., 2011; Berhie, 1991; DeLucia et al., 2010; Dimabayao, 2002; Pallot, 2011). Other major factors become a consequence of shortages of staff as well, such as staffing, which also results in inefficiency because of long hours of work that promotes stress among the staff. This was also noted in the study by Al-Malki et al. (2011).

Inefficient leaders can be attributed to the level of education and work experience of the health workers. Hence, there is deficit in leadership knowledge and skills. As Anderson (2013) stated, nurses are leaders and managers at some level. Thus, the results of this study support recommendations for supporting improved leadership skills among nurse leaders. Learning aspects of coaching, affiliative (with an emphasis on teamwork), and pacesetting (in which the manager sets high standards for achievement) leadership skills, these managers can support better results and implementation of the strategic plan. Using this type of leadership skill set, nursing staff will be able to improve their performance and connect their goals to those of the organization. Professional development for the nursing staff will help identify better ways of performing their jobs, also supporting job satisfaction among the nursing staff.

Benefits, especially sick leaves and undefined policies, were other major factors found to affect work performance. One reason for this is the absence of overtime pay. Addressing these factors is necessary to improve the work performance of the health practitioners and to increase satisfaction of clients, findings that also were found by Fort and Voltero (2004), and Omprommorat and Sriruercha (2013).

Supporting employee compensation and performance recognition through regular reviews will contribute to increased motivation among the employees to increase efficiency and performance, and ultimately job satisfaction in the workplace, which leads to higher patient satisfaction. Therefore, benefits in terms of recognition and compensation are critical to supporting both employee and patient satisfaction. This will be optimally supported through gaining a better understanding of their needs and problems and therefore leadership that holds concern for both the employees and the organizational results will support better results. In addition, motivational factors, such as recognition, sense of achievement, growth and promotional opportunities, responsibility and meaningfulness of the work are inherent to work, serve to motivate the employees for a superior performance. When employees are committed to, and have a stake in the organization's success, their needs and production needs coincide. Hence, a team environment based on trust and respect is created and this leads to high satisfaction and motivation. Because of this, high results are attained.



## 6.2 Recommendations

In order to address the issues identified through this study, the following recommendations are hereby advanced and can be seen in full detail in **Strategies to attain the goals of the strategic plan** (Appendix F).

**Human Resources management** may regularly maintain the employment records of the health practitioners in order to have complete information about them, ready for use whenever they are needed. Aside from their profile to be kept in their individual file, records of trainings attended, and a copy of the document showing their performance appraisal are equally important. This will enable management to trace development and progress of each staff member. Furthermore, these must be made accessible to persons who need them. Efforts to ensure confidentiality, however, must be observed. Goal 1: To maintaining an updated personal and professional file of health practitioners; To have a concrete and tangible basis of actions to be taken by human resources department, and hospital managers.

**Continuing education** is recommended for all health care practitioners such as those in this current study, to support competence and ultimately quality of patient care and level of patient satisfaction. In addition, providing opportunities for continuing education through real life experiences and collaborations within the workplace can support learning through a constructivist paradigm while supporting teamwork and collaboration in the workplace. Following recommendations for these types of opportunities and development can support job satisfaction as well as patient satisfaction. In addition, the organization will acquire benefits in terms of human capital, as the staffs become more highly trained and skilled to support greater efficiency in the workplace. Articulated in Goal 2: To provide opportunities for health practitioners in acquiring knowledge and skills on current trends and practices in health care; To increase satisfaction of clients, both inpatients and outpatients, on health care services and To acquire modern facilities in health care.

The results of this study support recommendations for supporting improved leadership skills among nurse leaders, as noted previously, with the specific use of approaches that support teamwork, and pacesetting leadership skills. With these skills honed, these managers can support better results and implementation of the strategic plan, improved staff performance, and job satisfaction. This will focus on Goal 3: To provide training to health managers on management

styles and leadership skill; and Goal 6; To reduce, if not eliminate the problems encountered in management services, To provide better management and leadership skills of health managers and To adopt management and leadership styles appropriate to the workplace

Given motivational factors that support job satisfaction among nursing staff particularly, it is recommended that organizations revisit the performance appraisal tool, for which it may be necessary to include other items deemed important. Furthermore, the procedure in measuring the performance of the health practitioners should be revised to include self-evaluation and peer evaluation, aside from the one made by the manager. Certain percentages from these data obtained may be allocated to determine the total and final performance rating of the health worker. This will be achieved by working towards Goal 1: To assess the work performance of the health practitioners regularly and Goal 4: To provide opportunities for qualified and deserving staffs for advanced education along with, To designate qualified staff appropriately and goal 6: To spearhead in initiating plans for development of staffs which are meant to increase work performance and satisfaction of clients/patients.

By implementing the Strategic plan (Appendix G) it is suggested that the issues and feedback identified from the survey and semi structured interviews in this study will be addressed and staff will achieve greater job satisfaction and job performance with a resulting improvement in patient care.

### **6.3 Limitations of the results of the research and Dissemination:**

Limitations to the work are the need for a mainly quantitative based research project due to an emphasis and value being placed on the positivist approach to research within the country. This may mean that the findings of this study are largely ignored or dismissed as the mixed method approach was used. However, from experience it seems that an increasing number of Doctoral thesis, specifically done outwith Saudi Arabia but by Saudi Arabian students are using mixed methods as a way forward and thus the research climate may begin to change.

A significant limitation to the study is the fact that the researcher was themselves a manager within the health system he was researching. This potentially raises questions of power and influence in terms of the results achieved (Dwyer and Buckle, 2009) and which may have influenced the

responses given particularly in the semi-structured interviews. The hierarchical nature of the health service in Saudi Arabia may also impinge on these results as participants may not feel able to offer a true expression of the perceptions and ideas for fear of retribution in some way; regardless that confidentiality will remain paramount. Finally that the work was undertaken in one specific area of Saudi Arabia which is a remote environment and therefore staffing may be more of a challenge than in a wealthier city, Therefore these results may not be reflected in more urban areas of Saudi Arabia where there are University Hospitals and potentially access to greater funding for education.

A final limitation to the work is that cognisance has to be taken of the political and cultural influences on the profession of nursing within the Kingdom, and thus articles may require to be sanitised of some detail to ensure the protection of participants and researcher. This in itself is a limitation to the study as important aspects may need to be redacted.

Dissemination will be undertaken by publication of articles and presentation at relevant conferences which are based on the results of the research, broken down by specific areas of results such as educational requirements.

## **6.4 Summary**

The aim of this mixed method, descriptive, cross-sectional study was to explore factors that influence health practitioners' performance with the objectives of (a) evaluating the profile of health practitioners and its implications to the delivery of healthcare services in the Jazan region, and (b) exploring factors that influence work performance and the needs of health practitioners. To achieve these goals, this mixed method study collected both quantitative and qualitative data in the form of survey and semi-structured interviews to gain a breadth and depth of results and allow for clarification of points. Data were collected from a total sample of 100 participants, 60 health workers and 40 health managers who work in the Ministry of Health facility in the Jazan region. The objectives of the study were addressed through the research and conclusions drawn from the findings and discussion.

With regard to the first objective, the data for this study showed little improvement over years past with a predominance of younger female, Asian expatriates, and with Saudi nurses demonstrating

an average of 6-12 years of experience, but working primarily as charge nurses despite lower educational attainment levels (Diploma rather than Bachelor's degree). Organizational effectiveness is dependent on the professionalism and competence of the staff; building competence and professionalism through advancing educational standards and professional development are key tenants to building staff competence (Oregon theory). It is recommended that further continuing education opportunities for staff members be provided to support advanced education and competence among the nursing staff, which will in turn support quality of patient care and satisfaction. Use of real world experiences, interactions, and peer collaborations can support advancement of the health care practitioner learners (constructivism theory) and more specifically, assist with the cultural and societal context of nursing in Saudi Arabia. In particular, such collaborations can be used to improve communication through understanding the language and culture, in addition to nursing practice.

With regard to the second objective, motivation through performance appraisal seemed to be accepted, although participants remained uncertain about remuneration, benefits, recognition, staffing, and work schedules. Health managers' management style and tasks were found to affect work performance through several major and intermediate factors, including staff shortages, inefficient leadership, .

Shortage of staff, as the number one major factor noted in this study, is still a condition that prevails in the kingdom, which supported findings of previous studies (Al-Malki et al., 2011; Berhie, 1991; DeLucia et al., 2010; Dimabayao, 2002; Pallot, 2011). Other major factors were related to staff shortages, such as long hours of work that promotes stress among the staff.

Inefficient leadership, attributed to the level of education and work experience of the health workers that results in a deficit of leadership knowledge and skills, was found to be a factor affecting work performance. Thus, the results of this study support recommendations for supporting improved leadership skills among nurse leaders. With coaching, teamwork, and pacesetter leadership skills, these managers can support better results and implementation of the strategic plan, support nursing staff performance, and connect goals to the organization.

Professional development for the nursing staff will help identify better ways of performing their jobs, while also supporting job satisfaction among the nursing staff.

Given the absence of overtime pay, benefits offered, especially sick leaves and undefined policies, was found to be another major factor to affect work performance and increase satisfaction. Employee compensation, performance recognition through regular reviews will increase motivation, job satisfaction, and ultimately, support increased efficiency and performance, and patient satisfaction through quality of care. Motivational factors, such as recognition, sense of achievement, growth and promotional opportunities, responsibility and meaningfulness of the work are inherent to work, serve to motivate the employees for a superior performance.

From the findings of the study, several recommendations were made toward development of a strategic plan. These recommendations were related to human resource management, continuing education for health care practitioners (using real life experiences and collaborations in the workplace), development of leadership skills, and use of performance appraisals. Implementation of the strategic plan (Appendix G), based on the findings of this study, should support greater job satisfaction and job performance among nursing staff, resulting in improved patient care.

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## **APPENDICES**

## **Appendix A: Saudi Health Care History**

Literatures of studies conducted on healthcare in the country revealed that shortage of Saudi health professionals, absence of a national management crisis policy, underutilization of the potential of electronic health strategies are among the problems which the kingdom are encountering as revealed in the study by Almalki, Fitzgerald and Clark (2011).

Indeed, the health workforce is a continuous problem in Saudi health care system due to shortage of local healthcare professionals such a physician, nurses and pharmacists. The majority of health personnel are expatriates and this lead to a high rate of turnover and instability in the workforce (WHO, 2010). Based on the data from the MOH of Saudi Arabia, the total health workforce in the kingdom is about 248, 000 and this number includes all other sectors providing health services. Of this total, more than half of them (125, 000) are employed in the MOH with Saudis comprise 38% (47,000) of this total workforce. Showing the composition of health workforce in the kingdom, the same source indicated that ratios of physician and nurses in Saudi Arabia are 16 and 36 per 10,000 populations respectively. This is lower than in other countries such as Bahrain (30 and 58 per 10, 000); Kuwait (18 and 37 per 10, 000), Japan (12 and 95 per 10,000), Canada (19 and 100 per 10, 000) and the United States of America (27 and 98 per 10, 000). These data implies that there is really a shortage of health workforce particularly nurses. Hence, there is a need to train and develop more nurses in order to provide quality health care to the population and to meet the ideal nurse-to-patient ratio. In 2012, the World Bank published the WHO's global health workforce statistics supplemented by OECD data. It showed that during that year, Saudi Arabia had 4.9 nurses and midwives per 1,000 people. This data shows that health care providers cater to the health needs of a big number of population. The article by Kaissi (2010) included the ideal nurse-to-patient ratio contained in California law which took effect on January 1, 2004. The law stated that nurse-to-patient ratios should be 1:1 in the operating Room; 1:2 in the intensive care, critical care and neonatal intensive care units as well as in post-anaesthesia recovery and labour and delivery; 1:4 in ante-partum, post-partum, paediatric care, emergency room and other specialty care units. General medical-surgical units are 1:5.

Relative to the statistics shown above, it was stated that shortage of health personnel in terms of number and level of performance are the major constraints in achieving the Millennium Development Goals (MDGs) for reducing poverty and disease. Some of the solutions proposed to

improve the situation are proper motivation, retention, productivity and performance of health practitioners and mobilizing trained staff who are working in other sectors to return to the health sector (High Level Forum 2004). Additionally, emphasis is placed on typical Saudi health workers in Jazan, Saudi Arabia coming from diverse nationality to make up for the high turnover among local nurses. From experience they mostly come from Southeast Asia such as Philippines, Indonesia, India, Pakistan and others from Arab countries like Egypt, Syria and other neighbouring Arab countries.

Although the shortage of Saudi healthcare professionals is compensated for by the recruitment of foreign workers, and they dominate the number of staff in hospitals or even in any healthcare facility (Pallot, 2011) yet it was noticed that present literatures about health care in KSA have not explored assessment of health practitioners particularly on work place, incentive and factors affecting work performance.

Recently, the kingdom has expanded its policy for the education of women. This is not only in accordance with the Saudization policy but one way of addressing unemployment among the nationals or locals. With this dramatic change of education in the kingdom, there has been an increasing number of enrolment and graduates among the Saudi nationals from different schools of allied health. However, it is still insufficient to meet the need of the required percentage of nationals to be employed in a particular establishment ([www.mol.gov.sa](http://www.mol.gov.sa); [www.moh.gov.sa](http://www.moh.gov.sa)).

## **APPENDIX B: MOH INTEGRATED AND COMPREHENSIVE HEALTHCARE PLAN Strategy**

The Ministry of Health Strategy for the next ten years (1431-1440 H) is coherent and consistent with the healthcare strategy in the Kingdom, ratified by the Council of Ministers' resolution No. (320), dated 17/9/1430, corresponding to 7/9/2009. Since the beginning of development plans in the Kingdom of Saudi Arabia, 40 years ago, the improvement of healthcare services provided to the Saudi citizens was a strategic option adopted by the Leadership. This huge interest in developing healthcare is embodied and manifested in Article 31 of The Basic Law of Saudi Arabia, "the State shall protect public health and provide healthcare to every citizen". In addition, this was also under the Eighth Development Plans, consisting of one concept; providing healthcare that meets the needs of the population in all over the Kingdom.

The Ministry has set this strategy, taking into consideration all the elements that would achieve the future vision in line with the development accomplished in health services sector around the world. In addition, the strategy is consistent with the roles played by the Ministry; the assigned authority to provide health services to the citizens, in addition to its responsibility of oversight and supervision of private sector facilities, as well as the development of legislation, rules and regulations for the provision of healthcare services to the citizens and residents of the Kingdom of Saudi Arabia.

This strategy comes in response to a series of major challenges facing the healthcare sector in various countries around the world, including Saudi Arabia. There is a huge new level of awareness among service recipients and their health education, in addition to a high level of expectations of better health services that can be accessed easily in accordance with high quality standards. The health sector is also witnessing many challenges worldwide, such as the high costs of health services resulting from the accelerating development of medical technologies in hardware, equipment tools and advanced and expensive medical technologies, as well as the unrelenting discoveries of new expensive drugs.

In addition, there are many other reasons for the rising demand for health care services, including the prevalence of chronic diseases, the diagnostic and therapeutic long term expensive care services, the increase of health awareness in the society, in addition to the increased demand for periodic checkup, risk factors monitoring and early disease detection and so on.

Through the current strategic plan, the Ministry of Health has implemented modern methodologies in providing health care services that makes the health system completely devoted to patients, or, in other words, a patient-centered health care system aiming to meet patients' health needs in the right place at the right time. This covers everything starting from primary health care till specialized therapeutic services in a professional manner, preserving all patients' rights, such as the right to know about their condition, the right to know the different treatment options, the right to choose their physician, and the right to be always treated with care and respect. These aspects didn't get a lot of attention in the past, but they are now one of the strategy's main objectives. The Ministry of Health strategy has adopted the integrated and comprehensive health care approach as a method of providing services, and implemented it through the MOH's Integrated and Comprehensive National Healthcare Project.

The MOH strategy includes other important aspects, such as health insurance, and the programs dedicated to study the role of cooperative health insurance, and considering including new segments of the community in it. It also includes the need to conduct studies on MOH hospitals in the future in terms of privatization, the best management

and operation practices, in accordance with the principles of economics, cost calculation, diversification of funding sources, and the optimal use of resources.

Nevertheless, huge health documents, articles, studies and research were used in preparing this strategy, in addition to numerous personal interviews and workshops, as well as the observations and suggestions filed to the Ministry from several bodies.

To view the whole MOH strategy (available only in Arabic), click on the picture below:



## APPENDIX C: PARTICIPANT CONSENT FORM

**Title of the Study:**

**FACTORS AFFECTING WORK PERFORMANCE OF HEALTH PRACTITIONERS IN JAZAN REGION**

I have read and understood the information sheet and this consent form.

I agree to take part in the study. I understand that I have no obligation to take part in this study.

I understand that I have the right to withdraw my participation in this study without giving any reason.

Name of Participant: \_\_\_\_\_

Signature of the participant: \_\_\_\_\_

Signature of the Investigator: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details of the investigator:

Ibrahim Ali Al-neami  
Training and Scholarship Administration  
Directorate of Health Affairs – Ministry of Health  
Jazan, KSA  
Email: [albra25@yahoo.com](mailto:albra25@yahoo.com)  
Telephone: (07) 324 4110

## **APPENDIX D: EXAMPLES OF TRIGGER INTERVIEW QUESTIONS**

- 1. CAN YOU TELL ME ABOUT HOW YOU WERE PROVIDED WITH THE OBJECTIVES TO BE ASSESSED?**

**FOLLOW UP QUESTION – WHY DOES THIS HAPPEN?**

- 2. HOW DID YOU KNOW THE FEEDBACK WAS CONSTRUCTIVE?**

**FOLLOW UP QUESTION – CAN YOU GIVE ME AN EXAMPLE OF THIS?**



## APPENDIX E: ETHICAL APPROVAL, PERMISSION TO CONDUCT RESEARCH

To: **The General Director of Health affairs**  
Ministry of Health (MOH)  
Jazan Region 45142  
Kingdom of Saudi Arabia

Date: **02 May 2012**

Subj.: **REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN JIZAN REGION AS PART OF THE REQUIREMENT FOR DOCTORAL DEGREE AT THE QUEEN MARGARET UNIVERSITY, SCOTLAND.**

I am a Saudi National, employed by the Ministry of Health, designated in Jazan region. I am registered with the Queen Margaret University, Scotland for a doctoral degree. The title of the intended thesis is "Factors affecting work performance of health practitioners in Jazan region, Kingdom of Saudi Arabia". I am expected to undertake research as part of the fulfillment of the requirements of the doctoral degree at Queen Margaret University, Scotland.

The purpose of this study is to identify and analyze factors that negatively and positively affect the health workers in Jazan and to explore factors that are strongly associated to these factors in order to suggest strategies for monitoring and improving performance of health workers which eventually leads to utilization of maximum capacity of the organization through the managers or its leaders.

I hereby request to submit questionnaires to a percentage of medical doctors, professional nurses and organizational managers to all Ministry of Health hospitals in Jazan region. Enclosed are the preliminary survey questionnaires for your perusal. Your favorable consideration will be highly appreciated.

Rest assured that all information will be treated in confidence and no reference will be made to a specific service or authority.

Sincerely Yours,

**Mr. Ibrahim Ali Alneami**  
PHD Student # S11007280

Approved by:

1) \_\_\_\_\_  
General Director of Health Affairs  
Ministry of Health, Jazan Region, KSA

2) \_\_\_\_\_  
Chairman, Research Ethics Committee  
Jazan Region, Kingdom of Saudi Arabia



## For Office Use Only

Ref. Number	
Assigned Reviewers	
Recommendation	
Outcome	



Queen Margaret University

EDINBURGH

**APPLICATION FOR ETHICAL APPROVAL  
FOR A RESEARCH PROJECT**

This is an application form for ethical approval to undertake a piece of research. Ethical approval must be gained for any piece of research to be undertaken by any student or member of staff of QMU. Approval must also be gained by any external researcher who wishes to use Queen Margaret students or staff as participants in their research.

Please note, before any requests for volunteers can be distributed, through the moderator service, or externally, this form **MUST** be submitted (completed, with signatures) to the Secretary to the Research Ethics Panel.

You should read QMU's chapter on "Research Ethics: Regulations, Procedures, and Guidelines" before completing the form. This is available at:

<http://www.qmu.ac.uk/quality/rs/default.htm>

Hard copies are available from the Secretary to the Research Ethics Panel.

The person who completes this form (the applicant) will normally be the Principal Investigator (in the case of staff research) or the student (in the case of student research). In other cases of collaborative research, e.g. an undergraduate group project, one member should be given responsibility for applying for ethical approval. For class exercises involving research, the module coordinator should complete the application and secure approval.

The completed form should be typed rather than handwritten. Electronic signatures should be used and the form should be submitted electronically wherever possible.

**Applicant details**

1. Researcher's name: Ibrahim Ali Neami \_11007280
2. Researcher's contact email address: albara25@yahoo.com
3. Category of researcher (please tick and enter title of programme of study as appropriate):

QMU undergraduate student	
Title of programme:	
QMU postgraduate student – taught degree	
Title of programme:	
QMU postgraduate student – research degree	Professional Doctorate in Health & Social Science - Full time
QMU staff member – research degree	
QMU staff member – other research	

## **APPENDIX F: STRATEGIES TO ATTAIN THE GOALS OF THE STRATEGIC PLAN**

### **Strategies for Goal No.1**

**To maintaining an updated personal and professional file of health practitioners is realized through:**

1. Making and maintaining a complete and systematic recording as well as filing of information and document pertaining to every health practitioner.
2. Giving every health practitioner the responsibility to submit to human resources management office all documents attesting her/his status, progress and development in the profession.
3. Periodic review of the personal and professional file of the health practitioners by the human resource manager so that he can give response as to who should be recommended for continuing education and training programs.

**To assess the work performance of the health practitioners regularly.**

1. Making a definite and sufficient timetable when to assess work performance of health practitioners.
2. Consultative approach in modifying or revising the assessment tool to include representatives from the health practitioners.
3. Other assessment tools should also be constructed to include peer evaluation.
4. Providing the health practitioners a feedback about the result of the performance evaluation.
5. Explaining the result of performance evaluation to the health practitioners and coaching them how they can overcome their weaknesses.
6. Making a follow-up to individual health practitioner on the adoption of recommendations given to improve performance.
7. Obtaining feedback (satisfaction evaluation) from clients/patients about the performance of the health worker who attended to their health needs.

**To have a concrete and tangible basis of actions to be taken by human resources department, and hospital managers.**

1. Making a comprehensive record on the status and result of work performance evaluation of health practitioners highlighting their strengths and weakness.
2. Providing the hospital manager of the comprehensive report made by the human resource office.
3. Making a different approach in conducting performance evaluation to include peer and self-evaluation aside from the one made by the manager.
4. Documentation of performance of every health practitioner.

### **Strategies for Goal No. 2**

**To acquire modern facilities in health care can be attained through:**

1. Benchmarking in healthcare facilities known to be modernized in Saudi Arabia and in other countries.
2. Making a budget or requisition of possible health care facilities and equipment with their equivalent cost and submit the same to the Director of the Ministry of Health.
3. Training the health practitioners on the use and care of the new facilities and equipment acquired.
4. Having a regular check-up and maintenance of these new facilities and equipment to ensure effectiveness and efficiency of use as well as longer years of service.

**To provide opportunities for health practitioners in acquiring knowledge and skills on current trends and practices in health care can be realized through:**

1. Designing a program of continuing education focused on current trends and practices in health care as well as on their weaknesses found during evaluation.
2. Inclusion of demonstration and return demonstration on current trends and practices especially on the use and care of the modern facilities and equipment acquired.
3. Evaluating the effectiveness of the continuing education program by way of written examination and return demonstration.
4. Including observation tours to other health care facilities or hospitals with modern facilities and equipment.

5. New and junior health practitioners may be assisted by their seniors on the use and care of the new and modern facilities in the hospital.

**To increase satisfaction of clients, both inpatients and outpatients, on health care services.**

1. Constantly reminding charge nurses and other staffs with direct contact with clients to do their best everyday;
2. Conducting a survey of patients' satisfaction on health care and services, both inpatients and outpatients;
3. Analysing the results of the survey so that strengths are maintained and weaknesses are overcome.

**Strategies for Goal No. 3**

**To reduce, if not eliminating the problems encountered in management services.**

1. Revisiting the job functions or responsibilities of health managers;
2. Making revisions or changes in job functions to make it more appropriate in the place of work and to conform to company policies;
3. Considering the results of assessment of their tasks and performance.

**To provide training to health managers on management styles and leadership skill.**

1. Administering a questionnaire to health managers that tries to discover and identify their management styles and leadership skills;
2. Inviting a resource person to analyse the result of the questionnaire who will also provide the training to improve their competencies and skills;
3. Coordinating with the Quality Assurance office on matters pertaining to management and performance;
4. Training on Total Quality Management should be provided.
5. Assessing regularly the work performance of health managers and giving them feedback about the result.

**Strategies for Goal No. 4**

**To provide opportunities for qualified and deserving staffs for advanced education.**

1. Revisiting the educational qualifications and performance of health practitioners;

- a. Health practitioners with a Diploma are encouraged to finish a bachelor's degree in Nursing/Midwifery through the bridging program.
  - b. Health practitioners with a Bachelor's degree who have potentials in management and with leadership skills may be recommended for advanced education through a scholarship program.
2. Formulating and using guidelines in the selection and recommendation of staffs for advanced education.
  3. Upgrading educational qualifications of present staff can also be done by recruiting new staffs that meet the current educational qualification required in the job.

#### **To designate qualified staff appropriately**

1. Reviewing thoroughly the qualifications, skills and performance of each staff;
2. Re-assigning the staffs in units/departments where their qualification and skills are mostly needed;
3. Conducting a regular work performance review as a way to assess the strengths and weaknesses of every health care practitioner.
4. Providing health practitioners with a regular training and attendance to continuing education and training programs to improve and provide current trends in the profession. Similarly, their knowledge, attitudes and skills may be improved.
5. Making provisions for the retention of qualified and competent nurses or any health care provider.

#### **Strategies for Goal No. 5**

##### **To overcome the shortage of health practitioners.**

1. Recruitment of more qualified staff but within the limits of the budget which the Ministry of Health can warrant;
2. Request the increase budget for the recruitment of more health practitioners to meet the desired nurse-patient ratio.
3. Manpower needs/requirements may be anticipated by keeping track of census and statistics of the hospital staff and personnel;
4. Preventive care must be promoted in the community thereby reducing cases attended by health practitioners or nurses at the hospital;

5. SWOT analysis may be done as a way of mapping possibilities to overcome staffing problems.

### **Strategies for Goal No. 6**

#### **To provide better management and leadership skills of health managers.**

1. Invite a research consultant to assess the management scenario of the hospital or health care facility so that appropriate management styles are recommended and tried out.
2. Conduct training on management and leadership styles and management planning as well.

#### **To spearhead in initiating plans for development of staffs which are meant to increase work performance and satisfaction of clients/patients.**

1. Undertake benchmarking activities in progressive hospitals and health care facilities in the kingdom and in other countries.
2. Adopting good practices on hospital administration and management observed from other hospitals in the kingdom and from other countries.
3. Design a comprehensive plan for staff development.
4. Create or revisit existing policies, guidelines and job descriptions/functions that address problems encountered in the workplace and factors affecting work performance.
5. Create or revisit existing evaluation tools to measure effectiveness of health workers, health managers and the whole operation in the hospital or health care facility.

#### **To adopt management and leadership styles appropriate to the workplace.**

1. Health managers may also undergo advanced studies and specialize on hospital management and administration.
2. Attending seminars, conferences and training programs relative to management and leadership.
3. Personal development by reading books, journals, magazines and online publications on management and administration.
4. Reading about cases on hospital administration and management.

## **APPENDIX G**

### **STRATEGIC PLAN TO ADDRESS THE IDENTIFIED FACTORS AFFECTING WORK PERFORMANCE OF THE HEALTH PRACTITIONERS**

The final content of the study is a strategic plan to address the identified factors affecting work performance of the health practitioners in Jazan region. Ultimately, the results of this study will be used in the development of staff in healthcare facilities in the region.

In recent years, it has been increasingly recognised that improving the performance of health care practitioners should be at the core of any sustainable solution to health system performance. It is also known that health workers are always at the frontline of being blamed for the poor outcome of health delivery services. However, looking at the health system globally, one can perceive that a single worker is not responsible for the operation of the whole organisation and so its output or performance. Desired output of a health organisation, as supported by literature, cannot be fully attained due to factors like insufficiency of skilled and experienced health care practitioners, demotivated health personnel, lack of management skills, poor working conditions and environment and inadequate remunerations.

With the above statements, it has become very apparent from the whole study that administrators and managers of hospitals and health care facilities are faced with a responsibility of improving the quality of their staffs. This can be done by providing them with continuing education and training programs. This will provide the health practitioners with current knowledge, skills and practices in health care. This is seen very important so that health care delivery in the kingdom is at par with other progressive countries in the world. Furthermore, the retention of competent nurses is very difficult to maintain. Hence, conducting staff development program through continuing education and training program is seen as a very good approach. Therefore, this chapter is a presentation of the ultimate goal of the study. It is the output of this study where the goals, objectives and strategies to achieve them are laid down. The framework will be of much help to human resources management in addressing the factors affecting the work performance of health care practitioners and at the same time promoting the quality of health care delivery in health care facilities in Jazan, Kingdom of Saudi Arabia.



## **8.1 Purpose**

The ultimate purpose of this study is to make a blueprint of strategic plans to address the factors affecting work performance of the health practitioners in Jazan region and improving health care services as well. Since the setting of the study is Jazan, these plans will be implemented in this region until its evaluation after two years. Elements found to be strong will be noted down while those ones still found to be weak will be provided with recommendations to overcome them. When everything is ironed out, it will be presented to the Ministry of Health for its possible implementation in the whole kingdom since problems in healthcare facilities encountered by health practitioners are practically similar.

### **A. Mission:**

Providing sufficient and adequate preventive, curative and rehabilitative health care in Jizan and in the kingdom.

### **B. Vision:**

To provide quality health care and services to all residents in the kingdom irrespective of socio-economic status, faith and nationality.

### **C. Goals:**

**No. 1. Conduct regular assessment of health practitioners' status and evaluation of the performance.**

#### **Objectives:**

1. To maintain an updated personal and professional file of each health practitioner in each health care facility.
2. To assess the work performance of the health care practitioners regularly.
3. To have a concrete and tangible basis of actions to be taken by the human resource department and hospital managers on the improvement of status and work performance of health practitioners.

**No. 2. Keep abreast with current trends and practices in health care management and services in the global arena.**

#### **Objectives:**

1. To acquire modern facilities in health care used in modern and current practices health care and practices.
2. To provide opportunities for health practitioners to acquire knowledge and skills on current trends and practices in health care.
3. To increase satisfaction of clients, both inpatients and outpatients, on health care services in all health care facilities.

**No. 3. Address the needs and problems encountered in management and services in health care facilities.**

**Objectives**

1. To reduce the problems encountered in management and services in health care facilities.
2. To provide training to health managers on management and leadership styles and skills.
3. To conduct regular and periodic assessment of the tasks and performance of health managers.

**No. 4. Upgrade educational qualifications of present staff in health care facilities and start recruiting new staffs that possess higher educational preparation, skills and competencies.**

**Objectives**

1. To provide opportunities for qualified and deserving staffs for advanced studies.
2. To designate qualified staffs after reviewing the qualifications, skill, competencies and performance of all health practitioners.

**No. 5. Have adequate and sufficient staff to provide quality care and services.**

**Objectives**

1. To overcome the shortage of health practitioners.
2. To consider and ideal patient/client-nurse ratio.

**No. 6. Re-tooling health managers with management and leadership skills**

**Objectives:**

1. To provide better management and leadership skills of health managers.

2. To spearhead in initiating plans for development of staffs which are meant to increase work performance and satisfaction of clients/patients.
3. To adopt management and leadership styles appropriate to the workplace.

The strategies to attain these goals and objectives are in Appendix B but available in Arabic only.

## **8.2 Roles and Responsibilities in the Implementation of the Strategic Plan**

The target group or recipients of the strategic plan are the health practitioners composed of health workers and health managers under the medical and nursing department in hospitals and other health care facilities under the Ministry of Health in Jazan region. It is because they were the subjects of the study and the factors affecting their work performance need to be addressed. Furthermore, they are in the frontline in the delivery of health services to the clients and in the community where they serve. When this is done, it will not only improve the work performance of the health practitioners but increase satisfaction of clients as well.

The investigator, being the Director of Scholarship and Training, is the project manager. As such, he takes the responsibility and accountability in the implementation of the strategic plan designed and presented in this study. A project team was organized so that there is an orderly way of realizing the goals, objectives and strategies set forth in the strategic plan. The members of the team were those who expressed interest to participate in the project when this study was on its conceptualisation stage. The principle of teamwork will be observed in the implementation of the strategic plan and that each member of the team will be responsible on the tasks and role assigned. The tasks and responsibilities were laid down at a meeting with them during the conceptualisation phase of the study.

The team is composed of a Chairperson, who is the present investigator and who has the authority of the plan. Besides, the Chairperson himself is the current Director of Training and Scholarship Administration in the Directorate of Health Affairs of the MOH in Jazan. His responsibilities in the implementation of the project are:

1. Leads the team in the full implementation of the project.
2. Approves the invitation of resource persons recommended to speak about topics in the different series of continuing education.

3. Recommends to the directorate of HOH in the region the approval of health practitioners who may undergo advanced studies.
4. Supervises the overall conduct of training programs for continuing education.
5. Prepares the budget necessary for the total implementation of the project, submits the same to the MOH for approval and make the necessary disbursements.
6. Conducts conferences before and after every training.
7. Spearheads in the evaluation of the project.
8. Keeps documents about the implementation and output of the strategic plan.

The team has also an Assistant Chairperson who happens to be the Assistant General Director of MOH in Jazan. As Assistant Chairperson, his responsibilities are:

1. Assists the chairman in the implementation of the project.
2. Brings matters for approval to the MOH relative to the implementation of the plan.
3. Supervises the preparation of training timetables and preparation of training modules.
4. Informs the Chairperson about problems encountered in all trainings conducted.
5. Reports to the Chairperson outputs of every training conducted.
6. Coordinates with other members of the team about.
7. Represents the Chairperson in conferences and other activities relative to the implementation of the project

There are three members of the team. They are the Nursing Director of King Fahd Central Hospital, the program coordinator of the Midwifery program in Jazan University and now the coordinator of the Nursing program in the same university. The third member is a staff in the Training and Scholarship Administration office. Their responsibilities are:

1. Prepare training timetables and training modules.
2. Become resource persons in topics relative to their specialization.
3. Invite other resource persons in line with topics and focus set in the training module.
4. Assist the resource persons regarding their needs during their presentation.
5. Coordinate with other human resources available in the venue of training regarding physical environment preparation and technical needs.
6. Responsible in the preparation and distribution of training materials
7. Document all activities in every training programs conducted.

8. Conduct evaluation and analysis of every training conducted.
9. Give reports/feedback and updates to the Chairperson and his assistant about the training program conducted.

### **8.3 Risks in the Implementation of the Strategic Plan**

Any project implemented may face some risks. When these are not anticipated, it affects the implementation of the plan. Risks that are viewed to happen could be on the identity of health practitioners to attend continuing education, project cost, timetable of activities, workforce and technical support and availability of beneficiaries to attend the scheduled training program. It is therefore necessary that there should be risk management and that contingency plans are laid down a well. Each risk that is identified has its corresponding contingency plan.

#### **8.3.1 Identifying the health practitioner to attend continuing education and training**

This particular plan is implemented for two years, after which evaluation will be made. Within this scope of that time, possible changes in the staff may be encountered. Some of the health practitioners may have already returned to their countries because they did not have their contracts renewed anymore or they may have transferred to other hospitals or health institutions outside of Jazan region. Therefore, the time to assess the profile of new staffs that replace them will take time in order to determine their skills and training needs. In this instance, identifying the health practitioners to attend continuing education will be a problem. In addition, this is seen as a potential problem in the sense that some of the staffs also, especially the locals, may leave due to their attendance to advanced studies. Hence, new staffs are needed.

#### **8.3.2 Project cost**

Another risk can be seen in the cost of the implementation of the plan. Budget allocations and cost estimates are made prior to the implementation of the plan. As such, the per capita is based from the current data or number of health practitioners that need to attend continuing education. Much more, one of the problems which this study is trying to solve is the shortage of staff. Recruitment of new staffs is always based on the capacity of the government to pay. In other words, the government has its own budget allocation for new staffs which means that it cannot recruit beyond

what the budget warrants. The number of new staffs to be hired will depend on the budget allocated for that purpose.

### **8.3.3 Timetable of activities**

This is a risk seen from two instances. First, health practitioners who are beneficiaries of the continuing education program prepared to improve knowledge and skills will come from different hospitals and health care facilities in Jazan region. Their schedule of duty may be in conflict with the timetable set for the training. The project team has no control of their work schedules in their respective assignments. Second, individual hospitals and health care facilities in Jazan region have their own programs, too, to implement. In this case, a conflict of timetable may arise. The health practitioners identified to attend continuing education under this project may also be attending an activity in their own work setting.

### **8.3.4 Workforce and technical support**

It is possible that some human resource tapped to help in the implementation of the project may withdraw or not available. The cause of withdrawal may be due to workload or overlapping of responsibilities during the implementation of the project. As it was always pointed out, shortage of staff, is a common problem in hospitals and health care facilities. This implies that when one or two are out, it results to increase in the usual workload.

Lack of technical support and availability and condition of equipment needed may cause delays and progression of activities in the project. Some of these are printing of training modules and other documents needed. Electronics and other communication media needed during the training also cause risks and problems. Persons assigned to handle these facilities may not be available during the time of training.

### **8.3.5 Availability of beneficiaries**

It has been identified previously that workload and overlapping of responsibilities is a potential risk and problem. In addition to this, unforeseen circumstances that befall on the health practitioners, like sick leave or vacation leave, are instances that cause their unavailability.

## **8.4 Contingency Plans**

In order to meet the potential risks and problems that may arise during the implementation of the plan, the investigator has come up with contingency plans. This is made to minimize the impact of any changes that may arise. Each potential risk and possible problem identified was provided with contingency plans.

### **8.4.1 On identifying the health practitioners to attend continuing education and training**

Since the investigator is the Chairperson in the implementation of the plan, he will see to it that health practitioners who will benefit from the project should be those ones who would be staying longer with the employer. Once these health practitioners have availed of the trainings through continuing education, there should be a condition that they should not leave after two year as the least. This is to make use of the investment of the MOH made on them. This is justified by the application of the Human Capital Theory.

Since Saudi nationals may be prioritized in going for advanced studies, then the number of staffs who leave because of this reason and purpose is determined beforehand. Therefore, the number of staffs who leave should also be the number of ne new staffs to be recruited. If financial resources still warrants, additional staffs may be hired following new guidelines to improve the status of the health practitioners like educational attainment as a bachelor's degree as the minimum.

With regards to the above, each hospital and health care facility may be encouraged to look into the qualifications and skills of their staffs as to who should be recommended to attend continuing education and training programs as designed in the strategic plan. Furthermore, they should be able to identify who among their staffs are still will to continue their services for two years more or even longer.

As to the number of new staffs to replace Saudi recipients of scholarship for advanced studies, this must be anticipated by each hospital and health care facilities so that the number needed may be forwarded to the MOH for the approval of replacements. Once done, recruitment can be done.

#### **8.4.2 On project cost**

The project cost is prepared before the implementation of the project. As such, calculations are based as to how many will be attending the training programs within the two years span of implementing the project. Cost of materials needed and honoraria provided to resource persons will likewise be determined. It is possible that there would be additional expenses needed during the actual implementation of the plan. In order to address this, an overhead cost may be included and indicated in the budget plan. In this way, the finances to support them are ready and already made available.

#### **8.4.3 On timetable of activities**

The principle of flexibility may be observed. Follow-up communications may be done remind beneficiaries of their attendance. This could be done through email and personal phone calls. If conflict of activities occur with the beneficiary, he or she may be replaced by another who is also a beneficiary of the goals of the strategic plan. This is the case if such conflict of timetable shows that it is the beneficiary who is affected.

Since the timetable of trainings to be given in the conduct of continuing education was prepared holistically, then it is not free from having conflicts of timetable with the individual timetables of activities made in individual hospitals and health care facilities. When such conflict of timetable arises in this case, the timetable of the training will be moved to another time. However, if more than 50% of the recommended beneficiaries are available, including replacements if ever there were, the time table of the training will go on as planned. This can be determined easily and quickly because of communications made with concerned individuals.

#### **8.4.4 On workforce and technical support**

Even though training modules, copies of programme and attendance certificates are already made available before the start of training, there would still be others and additional materials needed during the course of training. Therefore, the availability of the person responsible to do this work should present. Personnel attending to technical works, like those ones in-charge in information technology (IT), encoders, laptops, printers, internet, photocopiers, lights and sounds should be



informed to check on these before the start of all training conducted. Their availability during the course of training should also be ensured.

In addition, bond papers and other stationeries should always be available and sufficient. Sufficiency of these should be included in the budget outlay. Catering services should also be made prompt and punctual so as not to be a cause of any delay of activities

#### **8.4.5 On availability of beneficiaries**

The beneficiaries are the main reason why the continuing education and training programs are made. Therefore, their availability is very important and should be placed as the primordial concern. Primarily, assurance of their availability can be made through coordination with the manager of the hospital or health care facility where there are employed. Secondly, the commitment of the individual beneficiaries is equally important for whatever they acquire from the training will add to their knowledge, skills and capabilities thereby improving their work performance. Lastly, a copy of the complete timetable of training programs on continuing education will be given to hospitals and health care facilities in Jazan region. They will use this as reference in making their own timetables such that beneficiaries should not be assigned to have work on the days when trainings are conducted.

### **8.5 Evaluation Tools**

Assessment or evaluation is a part of any plan being implemented. It can be administered during or after the implementation of a project, program or plan. To do this requires the use of appropriate tools. Evaluation tools are important components in the implementation of a project, program or plan to determine how much was done and how much was achieved based from quantifiable targets. The investigator included evaluation methodology and tools to determine the effectiveness of the continuing education and training programs conducted.

The Six-Level Evaluation Methodology developed by San Diego State University was used as model. However, some of the items were revised to conform to setting. Accordingly, that university formulated this methodology based on Kilpatrick's four-level evaluation schema and these are

satisfaction/opinion, knowledge, behaviour and outcomes. However, they added two more levels which are tracking and formative.

<b>Six-Level Evaluation Methodology</b>		
Evaluation Level	Assessment	Evaluation Tool Needed
Level 1: Tracking	Who are attending/recipients of the training?  What experience/background do they bring that may affect the way the training is perceived or designed? Is the training valid?	Questionnaire (to be distributed prior to the start of the training).
Level 2: Formative	Does it address the needs and problems of the participants? What is the participant's opinion /satisfaction of the training received?	Content analysis and validity
Level 3: Satisfaction/Opinion	What is the trainer's opinion/satisfaction with the training delivered or conducted? Is there any change in the participant's knowledge, attitudes, and skills?	Satisfaction survey
Level 4: Knowledge/Skill Acquisition	Can the participant adequately perform the skills taught?  Has the participant self-perceived knowledge, skills, and comfort with the area of which the training changed? Is the participant able to transfer knowledge, values and skill taught in the training and apply them at work?	Pre/Post test Embedded Evaluation
Level 5: Transfer	What effect did the training have on the participant's ability to utilise the information?	Follow-up surveys Skills Assessment

Level 6: Outcomes	Has the training affected client outcomes?	
	What contributions and benefits has the participant made in his work setting after receiving the training?	Follow-up Surveys

As it was mentioned above, the investigator made some revision in the methodology to conform to the setting. One revision was on the evaluation tool needed in Level 2. Originally, that was Delta – Plus; now it is content analysis and validity. It is because this will be used in evaluating the training modules prepared. The other revision was on the inclusion of another guide question in Level 6. Since that concerns outcomes of the training program, therefore, looking into significant contributions and benefits the participant has given to his place of work is just but proper.

The drafts of the evaluation tools to be used will be made by the project team. The questions contained in the evaluation methodology as shown in the chart will be used as guides in making specific questions or details in the evaluation tools where they are needed. However, face, content and construct validity of these tools will be referred to an expert. These will be prepared prior to the start of the implementation of the series of continuing education and training programs. Furthermore, the training modules must have been finished, too.

The evaluation tool to be designed should have items which are quantifiable. This is to have a convenient way of having and understanding results. They may be expressed in frequencies, percentages or weighted means with equivalent descriptions. These quantifiable results would also easily give a feedback on the strengths and weaknesses of the training program conducted as well as on the different aspects which it wants to know based from the guide questions reflected in the evaluation methodology.

## **APPENDIX H**

### **LETTER OF REQUEST TO DISTRIBUTE QUESTIONNAIRES**

**02 May 2012**

**The Hospital Director**  
Gizan General Hospital  
Gizan Sector  
Jazan 45412 KSA

Dear Sir,

#### **REQUEST FOR PERMISSION TO SUBMIT QUESTIONNAIRES TO MEDICAL DOCTORS AND NURSES IN MANAGERIAL AND SUPERVISORY POSITIONS.**

I am currently doing a research for PHD degree at Queen Margaret University, Scotland. The title of the intended thesis is "Factors affecting work performance of health practitioners in Jazan region, Saudi Arabia". This study is undertaken for the fulfillment of the requirements of the doctoral degree at Queen Margaret University, Scotland.

The purpose of this study is to identify and analyze factors that negatively and positively affect the health workers in Jazan and to explore factors that are strongly associated to these factors in order to suggest strategies for monitoring and improving performance of health workers which eventually leads to utilization of maximum capacity of the organization through the managers or its leaders.

I hereby request to submit questionnaires to a percentage of medical doctors, professional nurses and organizational managers at the King Fahd Central Hospital. Enclosed are the preliminary survey questionnaires for your perusal. Your favourable consideration will be highly appreciated.

All information will be treated in confidence and no reference will be made to a specific service or authority.

Kind Regards,

**Mr. Ibrahim Ali Alneami**  
PHD Student # s11007280

## APPENDIX I

### RESEARCH QUESTIONNAIRE FOR HEALTH WORKERS

#### SECTION I

#### PERSONAL INFORMATION

Please give your answer to each of the following questions. Read all answers first and choose the appropriate answer box by circling only one number for each question

1. What is your age category?

20 -29 years	1
30 – 39 years	2
40 – 49 years	3
50 – 59 years	4
60 years or over	5

2. Nationality

Asian (Indian, Pakistan, Filipino, Indonesian)	1
Saudi	2
Other Arab nationalities (Egyptian, Syrian, Jordanian)	3
North/ South African	4
Other Nationality (Pls. Specify)	5

3. Gender

Male	1
Female	2

4. What is your highest educational qualification?

Diploma in nursing and midwifery	1
BSc Nursing and Midwifery	2
Bachelor's degree	3
Master's degree	4
Doctoral degree (e.g. PHD)	5
Medical degree	6
Others (pls. Specify)	7

5. What is your current specialty?

Nursing Category

Technician	1
Baccalaureate	2
Nurse Supervisor	3
Nurse Manager	4
Nursing Director	5
Nursing Deputy Director	6
Manager (specify which department)	7

Medical Category

Intern	1
Resident	2
Specialist	3
Consultant	4

6. How many years have you been a registered health practitioner?

0 – 5 years	1
6 - 10 years	2
11 – 15 years	3
16 – 20 years	4
21 years and longer	5

7. How many years of experience as a staff?

0 – 5 years	1
6 – 10 years	2
11 – 15 years	3
16 – 20 years	4
21 years or more	5

8. Language you can speak fluently

English	1
Arabic	2
Tagalog	3
Ortho	4
Others (Pls. specify)	5

## SECTION B

### HEALTH CARE PERFORMANCE ASSESSMENT, WORKSPACE AND INCENTIVES

Indicate your response to the following questions regarding performance appraisal and utilization in your organization or unit.

Kindly read each item in the following questions and then indicate with an X in the appropriate answer box, according to the following definitions. Please be guided by the codes below

1=Strongly disagree; 2=Disagree; 3=Uncertain; 4=Agree; 5=Strongly Agree

	STATEMENT	1	2	3	4	5
1.1	Objectives to achieved are known by individuals to be assessed.					
1.2	On-to-one performance interview on the outcome of performance appraisal is conducted.					
1.3	Performance standards expected from staff are clear and understood.					
1.4	Constructive feedback on performance appraisal results is provided in regular basis.					
1.5	Feedback of how the employee is performing is provided throughout the year.					
1.6	Prompt action is taken when performance falls below acceptable standards.					
1.7	Managers/supervisors inspires employees to do their best					
1.8	Employees are given the opportunity to comment on the results of their performance.					
1.9	Self assessment by employees to review their own performance is done.					

1. Please indicate your response to each of the following questions regarding your remuneration, benefits and recognition. Indicate an X in the appropriate box, according to the following code definitions:

1=Strongly Disagree; 2=Disagree; 3=Uncertain; 4=Agree; 5=Strongly Agree

	STATEMENT	1	2	3	4	5
2.1	Your remuneration is competitive compared to other organizations.					
2.2	Remuneration is in accordance with your experience.					
2.3	Remuneration is in accordance with your job responsibility.					
2.4	Fringe benefits are known to you.					
2.5	You are satisfied with your fringe benefits.					
2.6	Opportunities exist for career advancement.					
2.7	Hardworking employees are recognized.					

3. Please indicate your response to each of the following questions regarding staffing and work schedules. Indicate an X in the appropriate box, according to the following code definitions:

1=Strongly Disagree; 2=Disagree; 3=Uncertain; 4=Agree; 5=Strongly Agree

	STATEMENT	1	2	3	4	5
3.1	You get opportunities to make inputs into staffing policies and procedures.					
3.2	Opportunities exist for a flexible work schedule.					
3.3	The overall work schedule is fair					
3.4	Over time work is acceptable.					
3.5	There is a good balance between people who supervise work and people who do the work.					
3.6	The allocated staffs in my unit are sufficient to cover the current workload.					
3.7	Care and support of employees in the form of counseling at the place is available.					
3.8	Materials and supplies are sufficient.					
3.9	Necessary policies are available.					

4. Indicate your response to each of the following regarding staff development.  
Indicate X in an appropriate answer box according to the following code definitions:

1=Strongly disagree; 2=Disagree; 3=Uncertain; 4=Agree; 5=Strongly Agree

	STATEMENT	1	2	3	4	5
4.1	An opportunity for advancing in the organization exists.					
4.2	Good opportunities for continuing education care available					
4.3	The necessary training is given to ensure job effectiveness					
4.4	Job specific refresher courses are available					
4.5	In-service training adequately addresses the skill gaps					
4.6	Incompetent health worker are identified and provided with necessary prt					
4.7	Good leadership/ management training is available					
4.8	Health services participate in identifying their staff development needs					



## APPENDIX J

### QUESTIONNAIRE FOR HEALTH MANAGERS

#### SECTION A:

#### PERSONAL INFORMATION

Please give your answer to each of the following questions. Read all answers first and choose the appropriate answer box by circling only one number for each question

1. What is your age category?

20 -29 years	1
30 – 39 years	2
40 – 49 years	3
50 – 59 years	4
60 years or over	5

2. Nationality

Asian (Indian, Pakistan, Filipino, Indonesian)	1
Saudi	2
Other Arab nationalities (Egyptian, Syrian, Jordanian)	3
North/ South African	4
Other Nationality (Pls. Specify)	5

3. Gender

Male	1
Female	2

4. What is your highest educational qualification?

Diploma in nursing and midwifery	1
BSc Nursing and Midwifery	2
Bachelor's degree	3
Master's degree	4
Doctoral degree (e.g. PHD)	5
Medical degree	6
Others (pls. Specify)	7

5. What is your current specialty?

Nursing Category

Technician	1
Baccalaureate	2
Nurse Supervisor	3
Nurse Manager	4
Nursing Director	5
Nursing Deputy Director	6
Manager (specify which department)	7

Medical Category

Intern	1
Resident	2
Specialist	3
Consultant	4

6. How many years have you been a registered health practitioner?

0 – 5 years	1
6 - 10 years	2
11 – 15 years	3
16 – 20 years	4
21 years and longer	5

7. How many years of experience as a manager?

0 – 5 years	1
6 – 10 years	2
11 – 15 years	3
16 – 20 years	4
21 years or more	5

8. Language you can speak fluently

English	1
Arabic	2
Tagalog	3
Ortho	4
Others (Pls. specify)	5

**SECTION B:**

**MANAGEMENT, SKILLS DEVELOPMENT, PERFORMANCE ASSESSMENT**

1. Have you as a manager been involved with any of the following?

Answer either NO (1) or YES (2) for each of the following.

TASK	NO	YES
Managing conflict		
Operational conflict		
Counseling of employees		
Orientation of new staff		
Providing continuing education to employees		
One-to-one performance interview related to performance		
Placement of staff according to skills		

2. Have you received any management training or training in specific aspects related to management?

NO	1
YES	2

3. If YES, Can you please give the particulars regarding the management program or

Training you have attended?

Please indicate course(s) received	
Duration of course in days.	
In institution:	
Do you consider your training to be	
efficient?	
• Not at all	
• To some degree	
• To a large degree	
• To a very large degree	

2. Indicate how you regard your management skills for overseeing the effective functioning of the organization under your management. Indicate the following:

1 - Very poor	2 - Poor	3 - Average	4 - Good	5 - Excellent
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Knowledge / skills	1	2	3	4	5
Health service policy implementation					
Planning of health service delivery					
Development of performance standards					
Development of skills competencies					
Skills development					
Interpersonal relations					
Counseling skills					
Performance appraisal of subordinates					
Supportive management					
Problem solving skills					
Motivational skills					
Organizing facilities, equipment and supplies					

3. How is performance reviewed in your organization for various categories of employees?

A formal system of regular appraisals with reviews of past performance and setting of objectives.	1
Informal, but regular reviews involving discussions about past performance and agreed plans for the future.	2
Informal, ad hoc reviews, undertaken especially when there is a performance problem.	3